

# Overstretched. Under-resourced.

The UK nursing labour  
market review 2012



Royal College  
of Nursing

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## Acknowledgements

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## Executive Summary

- The 2012 Labour market review (LMR) of the UK nursing labour market highlights the impact of financial pressures on the current and future NHS nursing workforce. It shows that cost containment is contributing to reductions in the numbers of commissioned training and education places, to reductions in staff numbers, pay freezes and reduced training budgets for the nursing workforce.
- The report shows that all of these factors have an obvious impact on the size, shape and sustainability of the workforce, which in turn have implications for patient care. While there was growth in the NHS nursing workforce across most of the last decade, there are now increasing indicators of overall staffing decline, driven by reduced funding for intakes to training and much diminished levels of international recruitment. Workforce scenarios in NHS England strongly point to the likelihood of reduced supply of NHS nurses over the next five to 10 years.
- Just as the NHS appears to be facing increasing problems with the supply of nurses, workforce planning is also being confronted by different challenges including ongoing and significant gaps in nursing workforce data. In England, these shortcomings in data are compounded by uncertainty regarding the future of workforce planning structures. The report gives an overview of the new organisations which are intended to take over workforce planning in England, but goes on to explain that the new system is not yet fully defined or implemented, and is approximately a year behind schedule.
- The LMR looks at staffing numbers and up to date figures are not available for the whole of the UK, data for the NHS in England shows a reduction in nurse staffing of around 5,780 (headcount) and 3,700 (whole time equivalent) between May 2010 and June 2012.
- As well as a decline in the stock of current nurses, the major supply sources of new nurses to the NHS – pre-registration nurse education in the UK and international recruitment – have both been in decline. In the last decade, international recruitment made a major contribution to workforce numbers, yet this flow has slowed considerably due to a series of policy changes, including tougher NMC requirements and changes to the immigration system. The international contribution to the annual inflow to the NMC

register peaked at half of all new annual registrants in 2002 and now represents around 18 per cent.

- In the international context, the UK has moved from a situation of net inflow of nurses to a position of net outflow in recent years, meaning that more nurses are moving abroad than are coming to the UK to practice. The main destinations are Australia, Canada, New Zealand and the USA.
- The LMR looks at data for pre-registration education. In the early part of the last decade, pre-registration education, funded by UK government had seen investment in increasing numbers. This has now been reversed, with a year-on-year reduction to numbers across all UK countries. The declining level of funded training places is much lower than the supply of applications to enter pre-registration nurse education and is therefore a direct consequence of funding decisions.
- Experience from the 1990s shows that cutting student numbers led to a year-on-year reduction of new entrants from 18,980 in 1990/91 to 12,000 in 1997/98, which was a major factor contributing to an acknowledged nursing shortage later in the decade. This report highlights that there is a risk of repeating this funding and planning. In 2011/12 there were approximately 22,640 places across the UK, compared to 24,800 in 2010/11. Next year, there will another 1,260 fewer places with a total of around 23,380.
- This report also looks at trends in the use of bank and agency nursing staff and notes that it is virtually impossible to reach conclusions about its scale or scope, due mostly to the fragmented nature of data. There is also very little evidence on the impact of quality and continuity of care related to the use of temporary nursing staff. This lack of clarity around numbers and lack of transparency on the reasons for using temporary staff point to the need for improved evidence and data in order to better inform policy and planning.
- The LMR ends with an overview of the different systems of workforce planning in place across the four UK countries. It looks in most detail at England where radical restructuring is taking place, including a stated move to an employer-led approach. It warns of the risks involved in this approach, which was last attempted in the 1990s and led to an undersupply in the nursing workforce. It warns that cost containment pressures often lead to local employers taking a narrow, local view of their future requirements, without taking sufficient account of changed demand and of labour market dynamics and staff flows. As these narrow views are aggregated up to regional and national level, the end result can be a significant underestimate of future requirements for nursing staff.
- As a new system of workforce planning emerges slowly in England, all four UK countries face the same challenges of funding pressures, increased demand as well as an ageing nursing workforce. Against this background, the LMR concludes that across the UK there is a growing risk of insecurity of future nurse supply.

## Background

This report is the 2012 annual review of the UK nursing labour market commissioned by the Royal College of Nursing (RCN). In the twelve months since the last Labour Market Review (LMR) was published, the post-recession impact on the NHS workforce has become clearer, and for the first time since the annual LMR began publication in 2001 we report on an actual decline in NHS nurse staffing numbers across the four UK countries. Moreover, associated indicators suggest that the decline is likely to become a deepening trend unless remedial policy action is initiated.

Any assessment of the NHS nursing workforce must start from a position of acknowledging that NHS funding levels are a major determinant both of the current profile, and likely future shape of the profession. The NHS is the sole provider of funds for home based education of 'new' nurses to enter the UK nursing labour market, and is the main source of employment for qualified nurses. In addition, government policy plays a major role in facilitating, or blocking, entry to the UK of non-EU nurses.

Between 2011/12 and 2014/15 there will be very little growth, if any, in spending on the NHS. In England, the NHS must make up to £20 billion efficiency savings to meet the forecast growth in demand for health services over this period. NHS trusts and NHS foundation trusts face downward pressure on their income with 4 per cent efficiencies built into national tariffs and financial penalties if they do not meet performance standards<sup>1</sup>.

According to National Audit Office (NAO) estimates, of the four UK countries, Wales is predicting the lowest increase in expenditure on the NHS per person over the four years to 2014-15 – remaining almost constant in cash terms and equating to an average annual fall of 2.3 per cent in real terms. Real terms spending is also expected to fall by, on average, 0.6 per cent per year in Scotland and by 0.4 per cent per year in Northern Ireland, and to remain the same in England per year, between 2010/11 and 2014/15.<sup>2</sup> The most recent King's Fund panel survey of NHS finance directors in England reported that the majority thought that there was a high or very high risk of failure in achieving the £20 billion target beyond 2015<sup>3</sup>.

Cost containment in the NHS has led to reductions in the numbers of education and training places being commissioned, to NHS staffing reductions, to reduced investment in skilling up current staff, and to pay freezes. In previous LMRs we have highlighted the history of 'boom and bust' cycles of reduced intakes to training creating staff shortages and the subsequent need to scale up training and rely on high levels of active international recruitment to make good domestic training capacity shortfalls.

In last year's LMR we demonstrated that, under most realistic scenarios, there would be a sharp reduction in NHS nursing supply in England over the next ten years as a result of the reductions in intakes to pre-registration and an increase in retirements of the ageing NHS nursing workforce. The reality of a staffing decline over the last two years, which we discuss further in this year's report, is likely to be a continuing trend unless policy makers accept that

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<sup>1</sup> National Audit Office (2012) *Securing the future financial sustainability of the NHS*

<sup>2</sup> National Audit Office (2012) *Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland*

<sup>3</sup> King's Fund (2012) *How is the NHS performing? Quarterly monitoring report*

the current reduced intakes to pre-registration nurse education will make a significant contribution to reduced overall supply. There is also an associated need to develop a clearer and more realistic picture of just what level of 'productivity improvements' can be factored into these scenarios on future staffing levels.

This concern about reduced supply was echoed earlier this year by the Centre for Workforce Intelligence in its risks and opportunities assessment on acute nursing. It noted that workforce modelling suggested that demand for nurses would soon outstrip supply, with the gap between supply and demand forecast to widen over time<sup>4</sup>. It also highlighted that: "Although policy changes, demographics and increasing migration suggest that the requirement for adult nurses will continue to increase, feedback from the SHAs has shown that many are decreasing commissions. This poses a potential risk to service delivery... There is a significant risk that this could lead to future shortages."

In the 2011 LMR we expressed growing concern that policy makers and planners are currently faced by incomplete and indistinct evidence on the UK nursing workforce at a time when policy choices have to be made which will have major implications for the size, shape and sustainability of the nursing workforce, for patient care, and for individual nurses themselves. Whilst there have been some improvements in the rapidity of publication of NHS workforce data on the last twelve months, there remain major gaps in information on attrition rates, non NHS employment levels, and on levels of use, and reasons for use, of temporary nursing staff in the NHS.

In NHS England the continued shortcomings in data have been compounded by uncertainty regarding the shape of NHS workforce planning after the delayed implementation of NHS structural reforms. At the time of writing this report, the new system is not yet fully defined or implemented, and full implementation is running about one year behind the anticipated schedule that was set out at the end of 2010. The stated aim is to introduce an 'employer driven system' built around a new national organisation, Health Education England (HEE) and local commissioning bodies, local education and training boards (LETBs). Whilst the new workforce planning and commissioning structure in England remains incomplete, what is clear is that NHS cost containment pressure is impacting on workforce policy in all four UK countries. The NHS is labour intensive, and nursing is numerically one of the largest elements in the workforce, so it is not surprising that there is a policy focus on the workforce. In this year's LMR we update the analysis of the recent decline in NHS nurse staffing levels and in the reduction in domestic training, and we also highlight recent growth in inflow of nurses to the UK from other countries. We give specific focus to the use of temporary nurses in the NHS which has been regarded by some commentators as an indicator of system inefficiency, whilst others are suggesting that flexible staffing can be a source of productivity improvement in an era of fiscal constraint.

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<sup>4</sup> Centre for Workforce Intelligence (2012) *Workforce Risks and Opportunities: Adult Nurse Education Commissioning Risks Summary for 2012*

The remainder of the LMR is in five further sections:

**Section 2** profiles the current UK nursing workforce

**Section 3** provides a detailed focus on international flows of nurses to the UK

**Section 4** examines trends in the use of temporary nursing staff in the UK

**Section 5** reports on the supply of new nurses in UK pre-registration nurse education

**Section 6** concludes with an overview of developments in NHS workforce planning and considers where next?

## 2. The current UK nursing workforce

In this section we provide an overview of the current UK nursing workforce, with a main focus on NHS employment patterns and trends.

### 2.1 How many nurses?

In March 2012, 669,953 qualified nurses, midwives and health visitors were registered with the Nursing and Midwifery Council (NMC). This is the total pool of potential nurses and midwives available for employment. This was approximately 9,000 higher than the number reported in March 2011. Overall reported numbers on the register have fluctuated in recent years, with no clear trend.

The NHS is the main employer of nurses in the UK, but nurses also work in a range of other jobs and sectors. Data on nurses employed in the private sector, in nursing homes and other sectors is limited and has reduced in coverage, quality and completeness in recent years. This is occurring at a time when there is growing recognition of the need to capture non-NHS employment trends and to involve non-NHS employers in workforce planning, particularly in England, where the new NHS reforms point to greater involvement of non-NHS providers in employing nurses and in delivering NHS-funded health services.

NHS data on the nursing workforce cannot easily be aggregated up to UK level because of differences in definitions and collection methods in the four UK countries, so most trend analysis is best conducted at the level of country within the UK. Table 1 on page 7 uses national NHS workforce data from the four UK countries to assess overall growth in the last ten years. It shows that significant but variable levels of overall nurse staffing growth had been achieved over the period 2001/2011. The data in the table must be interpreted with caution for two main reasons. Firstly, definitions vary in the four countries and across time, which places limits on trend analysis within some countries (notably Scotland) and comparisons between countries. Secondly, measuring staffing change looking at two points in time can give little sense of variation in change across the period under examination, and can also be skewed by the choice of start and finish dates. This latter point will be examined and illustrated in more detail below.

**Table 1: Whole time equivalent and per cent change in the NHS qualified nursing and midwifery workforce, 2001 to 2011, four UK countries (September)**

	<b>2001</b>	<b>2011</b>	<b>%Change 2001 - 2011</b>
<b>England</b>	256,218	306,346	<b>20</b>
<b>Scotland</b>	36,425	41,495	<b>14</b>
<b>Wales</b>	18,088	21,733	<b>20</b>
<b>Northern Ireland</b>	11,502	13,649	<b>19</b>

*Sources: England: non medical workforce census, excludes bank and agency. The NHS Information Centre. Northern Ireland – DHSSPSNI; data is for March; Scotland data - ISD Workforce Statistics; Wales –StatsWales. Note: per cent figures are rounded.*

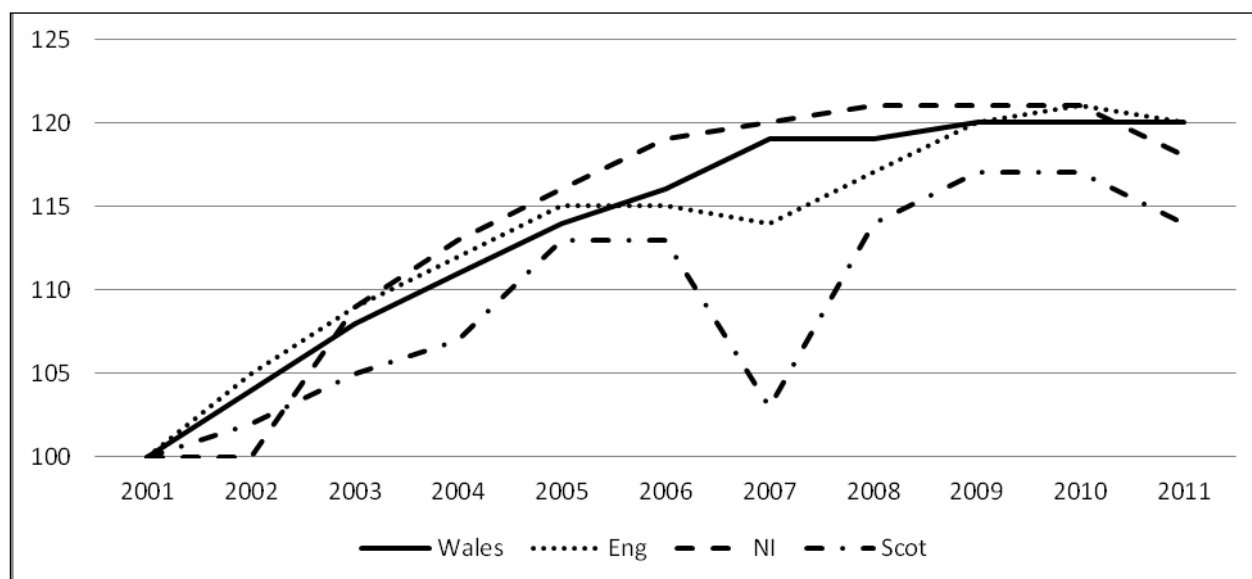
*NOTE: Scotland data for 2011 is not directly comparable with that from 2001 as data collection was re-calibrated using Agenda for Change bands after 2006. Data for 2011 is for bands 5-9.*

This headline percentage increase across the period reflects staffing growth in the earlier part of the last decade, driven by government investment in funding more nurse education places; implementation of policies to improve retention and return, and (mainly in England) a commitment to a policy of active international recruitment up to 2006. These policy-led interventions and funding support had in turn been a response to recognised NHS nursing shortages in the late 1990s.

Figure 1 on page 9 shows the trends in growth across the ten year period with 2001 as start date, for each of the four UK countries. This figure provides a graphical representation of the relatively rapid growth in the early part of the ten year period, followed by reduced growth rates, and more recently by a flat line or reduction in staffing. For all four UK countries there is a consistent pattern of an arching curve of growth towards the end of the last decade, followed by an actual reported reduction in three of the four UK countries in 2010/2011 (data definitional issues and delays in assimilating some staff during the transition to Agenda for Change in 2007 explain the apparent blip in that year, most notable for Scotland).



**Figure 1: Annual trend in NHS qualified nursing workforce, four UK Countries, (Index 2001=100)**



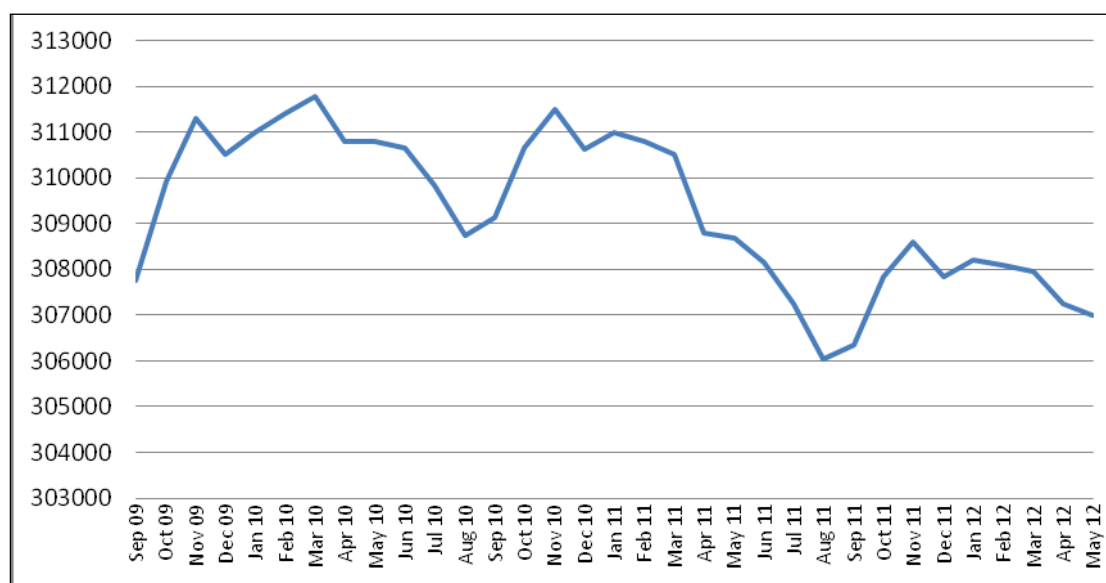
*Source: data sources as per Table 1*

The available comparable national data for the UK countries is at least several months old by the time it is published and as such it may not be an accurate representation of the current situation. This means that policy makers at national level cannot rely on these data to give an up-to-the-minute picture of staffing change. However there have been some recent improvements in the timeliness of data provision by the NHS Information Centre in England and the Information and Statistics Division (ISD) of NHS Scotland, which provide quarterly data at a more rapid cycle of dissemination. NHS Scotland has also asked all NHS Boards to provide workforce projections for 2012/13. The aggregated estimates on staffing change for 2012/2013 show a estimated national increase of 113.6 WTE (up 0.1 per cent), but an estimated reduction in Nursing and Midwifery of 325.0 WTE (down 0.6 per cent) (this estimate includes an estimated increase of 174.8 WTE interns who are supernumerary). The overall reduction is linked to the transfer of 109.8 WTE nursing and midwifery staff from NHS Highland to Highland Council on 1st April 2012<sup>5</sup>.

The latest data for England showed a reduction in NHS nurse staffing of 5,780 by headcount and around 3,700 whole-time equivalents. Figure 2 gives more detail on the recent monthly trends in NHS and highlights some seasonal fluctuation, with relative staffing growth in the period September-December, and relative decline in the spring/summer up to August. While there has been an overall decline since 2010, this highlights the risk of assessing staffing change using arbitrarily chosen start and finish months.

<sup>5</sup> [www.scotland.gov.uk/Publications/2012/08/7784/3](http://www.scotland.gov.uk/Publications/2012/08/7784/3)

**Figure 2: NHS qualified nurses, England, Sep 2009-May 2012 (WTE)**

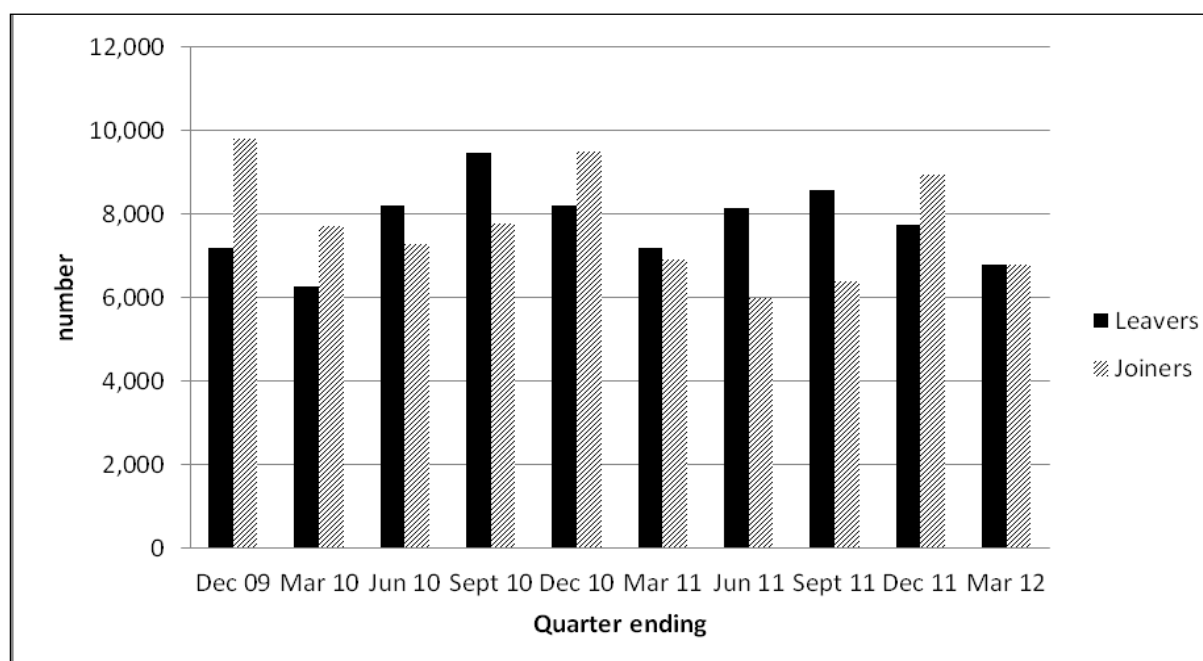


*Source: NHS Information Centre*

The headline change in the overall number of NHS nurses reflects a continuous process of joiners and leavers – new nurses entering the NHS, whilst others leave. Quarterly data on joiners and leavers from the NHS nursing workforce (Figure 3 on page 11) shows some seasonal fluctuation, with the annual number of joiners peaking in the quarter ending in December (perhaps as a result of newly qualified graduates entering the job market), a broader pattern of excess joiners over leavers in the third and fourth quarters and excess leavers in the first and second quarters but gives no conclusive picture of a trend either of net growth or decline in more recent months.

Overall, the available data shows a clear tailing off in the rate of NHS nurse staffing growth in the four UK countries, and a more recent decline.

**Figure 3: Quarterly turnover of qualified nursing staff, NHS England, 2009-12**



*Source: NHS Information Centre*

A secondary issue, and one that is examined in more detail later in section 4 of this report, is the use of temporary nursing staff (bank and agency). Given the importance to overall workforce planning and policy to have a clear sense of the extent of deployment of temporary nurses this is a growing concern. The absence of consistent data on the level of use of temporary staff makes it extremely difficult to assess their overall contribution, and determine if this is increasing or decreasing.

## 2.2 Why has staffing growth ended?

The supply of new nurses to the NHS and to other employers in the UK comes mainly from pre-registration nurse education in the UK, and, in some time periods, from international sources. Supply from UK pre-registration education has been the major source in recent years, whilst international recruitment made a major contribution in the earlier part of last decade.

Pre-registration education is funded by UK governments, and in the early part of the last decade all four UK countries invested in increasing numbers as part of the overall approach to scaling up the nursing workforce in response to recognised staff shortages. This has now been reversed, and as discussed in detail in the next chapter, there is now a year-on-year reduction in intakes to pre-registration education evident across the four UK countries.

In essence, UK governments and policy makers determine how many nurses are being trained in the UK through allocation of funding. Every year there are more applicants for

nurse education in the UK than there are funded training places. Therefore the numbers of nursing students entering UK pre-registration education in the UK and subsequently entering the UK register when they qualify is not a random or uncontrolled event, and is not supply constrained, it is the direct result of funding decisions and subsequent career choice by individuals.

There is also an inevitable time lag of three to four years between people entering pre-registration nurse education, and these newly-qualified nurses entering the labour market. This emphasises the need to have a clear sense of future supply and demand, locally and nationally, in order to ensure that the commissioning process is cost effective, responsive and flexible in responding to changing trends and demands. It also highlights that if this process is based only on a short term or restricted focus, there is an increased risk of creating future over- or under-supply.

As noted in the introduction, there is currently an absence of detail on how the new workforce planning and commissioning process will function in NHS England, but there is an expressed commitment to make it employer led. Experience in the 1990s with locally-driven NHS workforce planning highlighted that there is a considerable risk of creating national undersupply with a locally-led approach to planning. Where there is cost containment pressure in the NHS, local employers often take a narrow, localised view of their future requirements. In addition, the staffing needs of non-NHS employers can be overlooked, as highlighted above. If all these local, narrow views are aggregated up to regional and national level without sufficient checks and balances made to consider wider labour market dynamics, then the end result can be a significant underestimate of future requirements<sup>6</sup>.

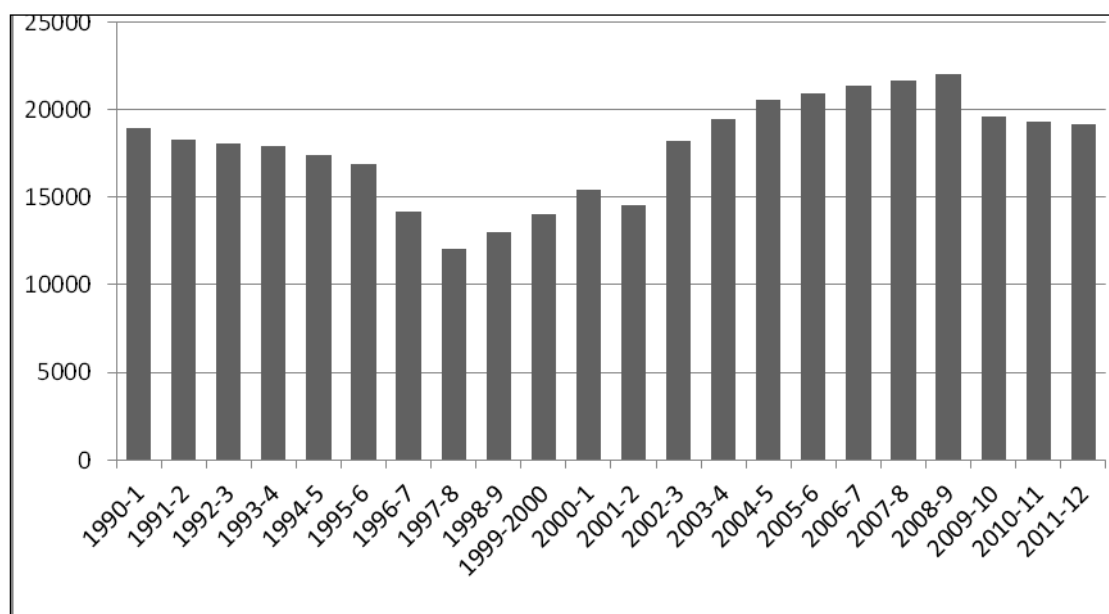
Figure 4 on page 13 shows the annual number of new nurses entering the UK register from education and training in the UK since 1990, and illustrates this point. In 1990/91 there were 18,980 new entrants. The annual number of entrants fell year on year to a low of just over 12,000 in 1997/98, the direct result of funding decisions to reduce the number of pre-registration places on offer, despite clear evidence from scenario planning that this number was too low to meet future demand<sup>7</sup>. The consequent drop in UK entrants was predictable, given decisions to reduce funding for pre-registration places, and was a major factor contributing to acknowledged nursing shortages later in the decade.

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<sup>6</sup> Buchan J, Seccombe I and Smith G (1998) *Nurses' work: an analysis of the UK nursing labour market*. Aldershot: Ashgate Press

<sup>7</sup> Buchan J, Seccombe I and Smith G (1998) *ibid*

**Figure 4: Number of new entrants to the UK nursing register from UK sources: 1990/1 to 2011/12**



Source : NMC

This led to the self imposed nursing shortage that the UK experienced in the mid/late 1990s, which then had to be addressed by a combination of increased UK training and high volume active international recruitment. Increased funding meant that there was a significant upward trend in intakes after 1997/98, and the increase in pre-registration places led subsequently to more new nurses coming out of pre-registration education in the UK, as can be seen in the figure. The new intake from UK education reached 22,000 in 2008/9, but has subsequently dropped to less than 20,000 per annum in the period since 2009/10, a sign that recent reductions in funding for intakes is beginning to have a knock on effect on numbers of new UK nurses entering the register.

## 2.3 Summary

For the first time in decades there is clear evidence that the overall number of nurses employed in the NHS across the four UK countries has declined. UK governments and policy makers determine how many nurses are being trained in the UK through allocation of funding. There continue to be more applicants for nurse education in the UK than there are funded training places. The numbers of nursing students entering UK pre-registration education in the UK and subsequently entering the UK register is not a random or uncontrolled event, or a reflection of lack of potential recruits, it is the direct result of funding decisions and subsequent career choice by individuals.

### 3. An upsurge in international nurses?

#### 3.1 Introduction

International recruitment of health professionals can be attractive to policy makers because it enables rapid recruitment without the expense and lead-in time that commissioning more home-based training places requires. In the period between the late 1990s and mid-part of the last decade, organisations in the UK, particularly England, actively recruited nurses from a broad range of countries. In this section, recent international trends and drivers are examined.

#### 3.2 Trends in inflow

Whilst there is not precise data on how many international nurses were recruited to, arrived in, and continued to work in the UK, between 1998 and 2006, there were approximately 100,000 new non-UK nurse registrations with the NMC across that period.

However, there then followed a period when there was rapid decline in inflow of nurses to the UK from other countries. This change was in part a result of reduced demand in the UK, but also reflected a change in policy stance. Whilst nurses from other EU countries continue to have free access to the UK, under EU Directives, those from other countries have experienced increasing difficulty and costs in attempting to travel to work in the UK.

A series of policy changes has made it much more difficult for non-EU nurses to enter the UK. Firstly, in 2005 the NMC instigated a much tougher (and costlier) programme for overseas nurses intending to practise in the UK, the Overseas Nurses Programme (ONP)<sup>8</sup>. Secondly, in 2006 the main entry clinical grades in the NHS were removed from the Home Office shortage occupation list. Thirdly, in 2007 the NMC then also raised the English language test requirements. Fourthly, in 2008 the UK immigration policy changed, with the introduction of a points-based work permit system, making international recruitment a more difficult option for employers. More recently, there has been further toughening of immigration policy. In May 2010, the UK government announced their intention to review the immigration system to ensure that net migration reduced between 2010 and 2015 to the levels previously seen in the 1990's. New immigration rules were brought into force in April 2012 in relation to the approach to granting work permits to new entrants, and approving resident status for non EU nurses currently working in the UK on time limited work permits.

The cumulative impact of these self imposed changes is shown in Figure 5 on page 15. This figure uses annual registration data from the NMC, and its precursor, the UKCC. The key indicator is the level of initial admissions to the NMC Register, of nurses and midwives originally trained and registered outside the UK<sup>9</sup>. The figure shows the annual number of

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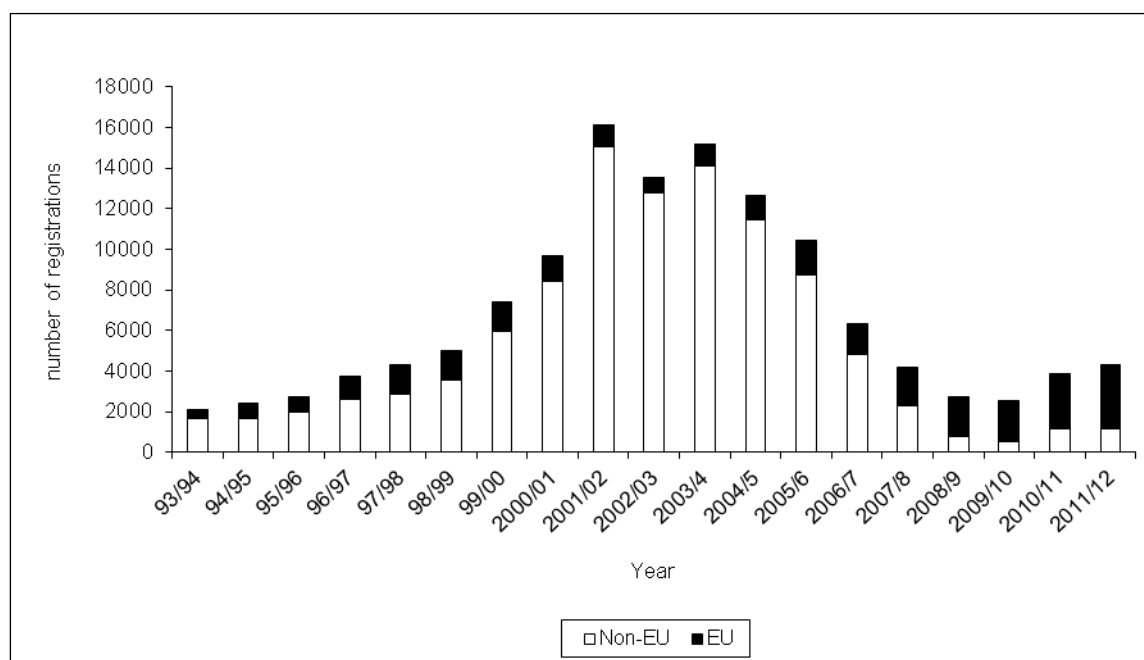
<sup>8</sup> Nursing and Midwifery Council, *Trained outside Europe: Information for nurses and midwives who trained outside of the EU or EEA countries*

[www.nmc-uk.org/Registration/Joining-the-register/Trained-outside-the-EU--EEA/](http://www.nmc-uk.org/Registration/Joining-the-register/Trained-outside-the-EU--EEA/)

<sup>9</sup> There are limitations in using NMC data to monitor the inflow of nurses to the UK, because it registers intent to work in the UK, rather than the actuality of working. Overseas nurses may be

new registrants who had come from countries within the EU, and from other international sources.

**Figure 5: Admissions to the UK nursing register from EU countries and other (non EU) countries 1993/4 to 2011/12**



*Source: NMC/ Buchan and Seccombe*

Three key points are evident in examining Figure 5. Firstly, after rapid growth in inflow of nurses to the UK from the late 1990s to the early part of last decade, there was then a marked decline in the overall annual number of new registrations across the period from 2004/2010. Secondly, more recently, from 2010/2012, there has been an upswing in inflow from both EU and non-EU countries. Thirdly, the numbers of nurses from EU countries have increased from a relatively small annual level, to the current situation where they represent the majority of the inflow.

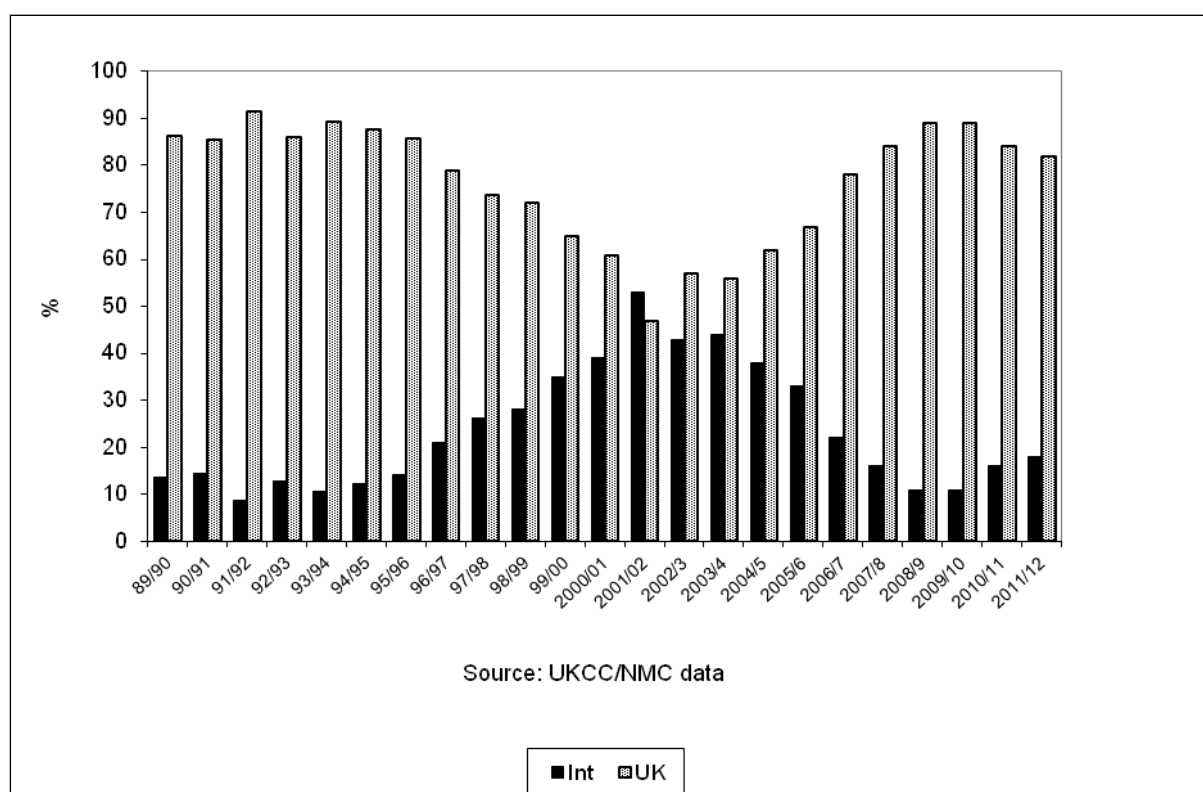
The first and second points are emphasised in Figure 6, below which shows the relative size of inflows to the UK register from home-based training and from international sources (EU and non-EU). The international contribution peaked at more than half of all new annual registrants in 2002, then declined rapidly until 2010, when it represented only one in ten of new registrants. However, since 2010, the international contribution has grown, reaching about 4,000 new registrants in 2011/12, double the number of two years earlier, and representing about 18 per cent registrants that year. Romania, Portugal, Spain and Ireland were the main EU source countries, whilst India and the Philippines were the main non-EU sources. Whilst it is too early to be clear if this represents the beginning of an upsurge in

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registered, but not move to the UK, or they may move to the UK but not take up employment in nursing.

international inflow, it is apparent that the decline up to 2010 has now been reversed, in overall terms.

**Figure 6: International and UK sources as a percentage of total new admissions to the UK nursing register, 1989/90 to 2011/12**



Source: NMC/ Buchan and Seccombe

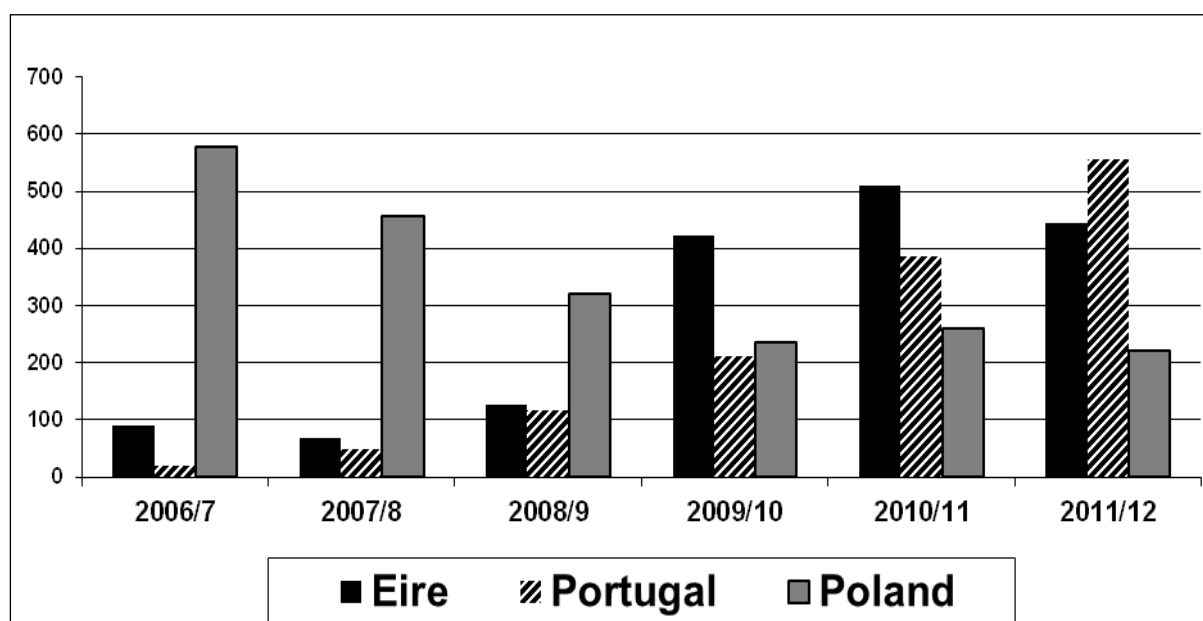
It is also apparent that the increase in inflow has occurred in both EU and non EU nurses, but that the former now comprise the majority. The policy relevance of this last point is that EU nurses have free mobility to enter the UK when they wish. They are not subject to immigration controls, and from a UK policy and planning perspective are an 'unmanaged' inflow; they cannot be directed, and the length of their stay in the UK cannot be determined. Given ease of movements and relatively cheap travel costs between the UK and EU countries, it is also likely that there will have been an increasing number of 'commuting' EU nurses, who travel frequently between the UK and other countries in the EU on a regular basis<sup>10</sup>. These changing dynamics highlight that international flows will be less open to 'management' by UK policy makers and regulators, with the majority inflow from the EU, and length of stay in the UK, being determined primarily by individual choice and circumstances of the nurse.

<sup>10</sup> Wismar M, Maier C, Glinos I, Dussault G and Figueras J (2011) *Health Professional Mobility and Health Systems: Evidence from 17 European countries*. WHO European Observatory, Brussels



The growth in significance of inflow from the EU has been triggered by two events. Firstly, the entry of accession countries to the EU in the mid-part of the last decade enabled nurses in these countries to move freely within the EU, and this led to an initial growth in nurse entrants to the UK from new EU states such as Poland and Romania. Secondly, and more recently, there has been a marked increase in nurses registering in the UK from EU countries experiencing extreme labour market problems in the eurozone economic crisis. Nurses from countries such as Portugal and Spain have not been traditional entrants to the UK, but there has been a sudden marked increase from these countries (see Figure 7 below).

**Figure 7: New admissions to UK register from selected EU countries 2006/7 to 2011/12**



Source: NMC/ Buchan and Seccombe

Figure 7 shows new admission from selected EU countries since 2006. Different patterns of inflow from different countries are clear. The number of nurses admitted to the UK register from Portugal, one of the crisis countries, has grown from 20 in 2006/7 to more than 550 in 2011/12. Whilst some of this flow will represent a 'push' from poor employment opportunities in Portugal, there have also been media reports of active recruitment of Portuguese nurses by NHS organisations in 2012<sup>11, 12 and 13</sup>.

<sup>11</sup> Conceição C, Ribeiro J, Pereira J and Dussault G (2011) *Portugal: Mobility of Health Professionals*, Associação para o Desenvolvimento da Medicina Tropical, Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa.

[www.mohprof.eu/LIVE/DATA/National\\_reports/national\\_report\\_Portugal.pdf](http://www.mohprof.eu/LIVE/DATA/National_reports/national_report_Portugal.pdf)

<sup>12</sup> Howie M (2011) *Spanish and Portuguese nurses fill the gaps in the NHS*. The Guardian, 20 December

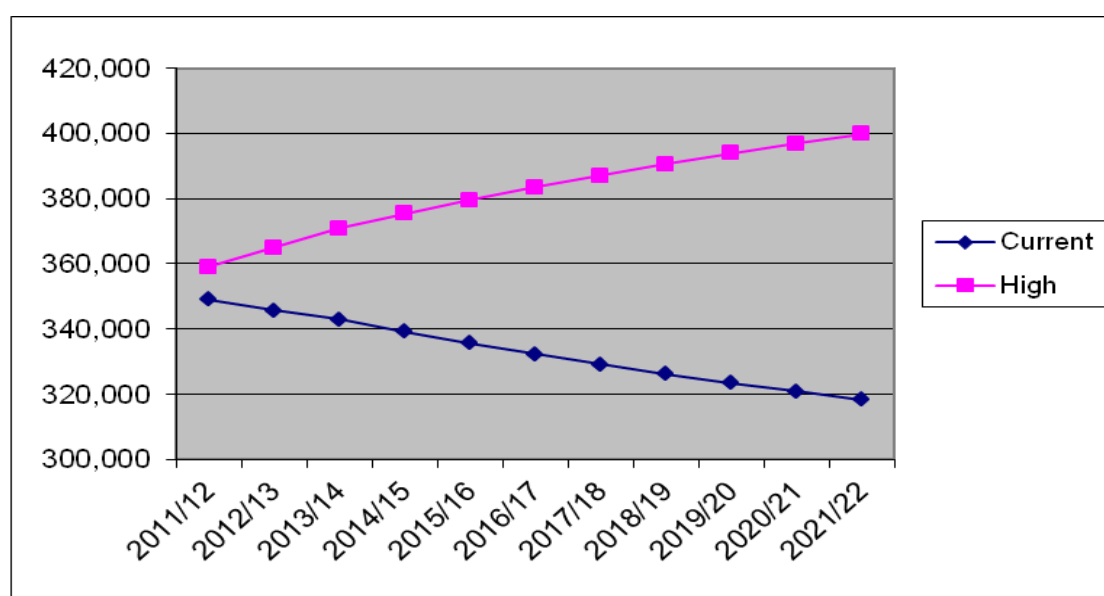
[www.guardian.co.uk/society/2011/dec/20/nurses-spain-portugal-fill-gap-in-nhs](http://www.guardian.co.uk/society/2011/dec/20/nurses-spain-portugal-fill-gap-in-nhs)

<sup>13</sup> Williams D (2012) *Trust looks to Portugal for new nursing recruits*. Nursing Times, 26 July

Another crisis country, Ireland, has been a traditional source of nurse recruits for the UK, but by the middle of the last decade, the Irish economy and health service were expanding, and Ireland became one of the most active recruiters of nurses, whilst also retaining most that it trained. Ireland became one of the most active recruiters of nurses in the English speaking world<sup>14</sup>. In 2006/7 fewer than 100 nurses from Ireland were registered in the UK; three years later that figure had increased to more than 400 as the crisis hit the Irish health system and job opportunities for nurses reduced drastically. Poland, one of the accession states, initially was the source of several hundred registrants per year in the UK, but in more recent years the number of registrants has dropped: this may be a reflection of the fact that the Polish economy has fared relatively well in the economic crisis.

The potential contribution of international recruitment of nurses to the UK can be shown by using a NHS nursing workforce model developed in 2011, and using it to assess the implications of projecting forward historically 'low' and 'high' levels of inflow of nurses to the UK<sup>15</sup>. Figure 8 below shows the trend in NHS nursing supply if historically current [c 2010] or historically high [c 2002] annual international inflows were maintained up to 2021.

**Figure 8: Total supply of NHS nurses under "low"(current) and "high" scenarios of inflow of international nurses, 2011-2022**



Source: Buchan and Seccombe

The outputs from this modelling with current and high international flows being projected, and all other inflows and outflows being held constant highlights just how significant can be the impact of international recruitment on the total stock of the NHS nursing workforce. The end result is 33,750 fewer NHS nurses in 2021/2 than in 2011 under the low international

<sup>14</sup> Humphries N, Brugha R and McGee H (2009) *Retaining Migrant Nurses in Ireland II. Nurse Migration Project Policy Brief 3*. Dublin: Royal College of Surgeons in Ireland

<sup>15</sup> Buchan J, Seccombe I (2011) *A decisive decade: The 2011 UK nursing labour market review*. Royal College of Nursing: London  
[www.rcn.org.uk/\\_\\_data/assets/pdf\\_file/0006/405483/LMR2011\\_FINAL.pdf](http://www.rcn.org.uk/__data/assets/pdf_file/0006/405483/LMR2011_FINAL.pdf)

inflow scenario, or 47,700 more nurses if international inflow is projected at the historically high level: a gap of more than 80,000.

### 3.3. Outflow of Nurses from the UK

International flow of nurses is two way. Recent UK nursing journals carry advertisements from a range of other countries aiming to recruit UK nurses, and there have been specific attempts by Australian recruiters to deliberately target areas of the UK, where NHS job cuts and recruitment freezes have been announced.

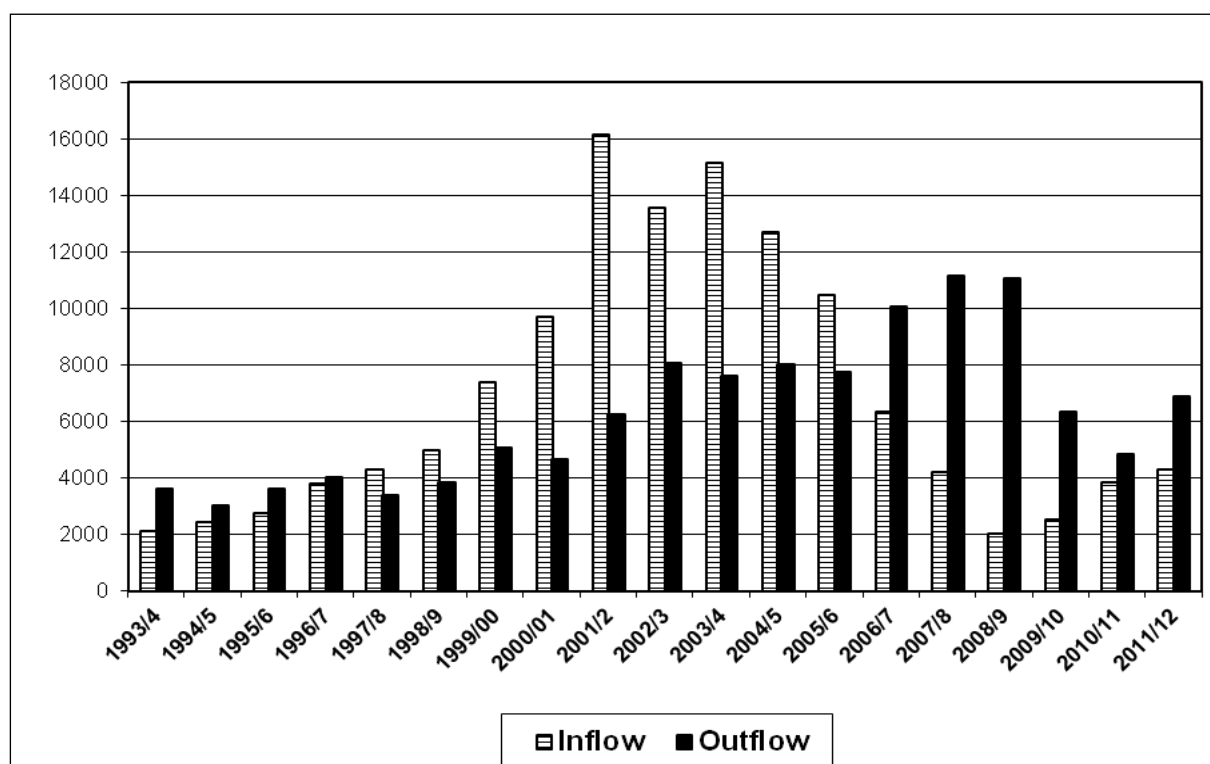
Some estimates of the outflow of nurses from the UK can be determined using data held by the NMC on verifications reported to other countries. Whenever a UK registered nurse applies for registration in another country, that country's registration body should contact the NMC for verification of the nurse's details<sup>16</sup>.

Overall trends in this measure of outflow are shown in Figure 9. The annual number of verifications issued increased steadily across the period from 2001/2 to 2008/9, then dropped, and appears to have grown in 2011/12. In comparison to inflow as measured by new registrations, it is clear from the figure that the UK has moved from a situation of likely net inflow in the first half of the last decade to a position of net outflow in recent years.

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<sup>16</sup> The NMC data indicates an intention to nurse in other countries, it does not necessarily record an actual geographical move. There will also be some double counting when a nurse applies to move to more than one country, and some of the outflow will be of foreign nationals who, having undertaken pre- or post-registration nurse education in the UK, return home.

**Figure 9: Inflow and outflow of nurses from the UK, 1993 to 2012**



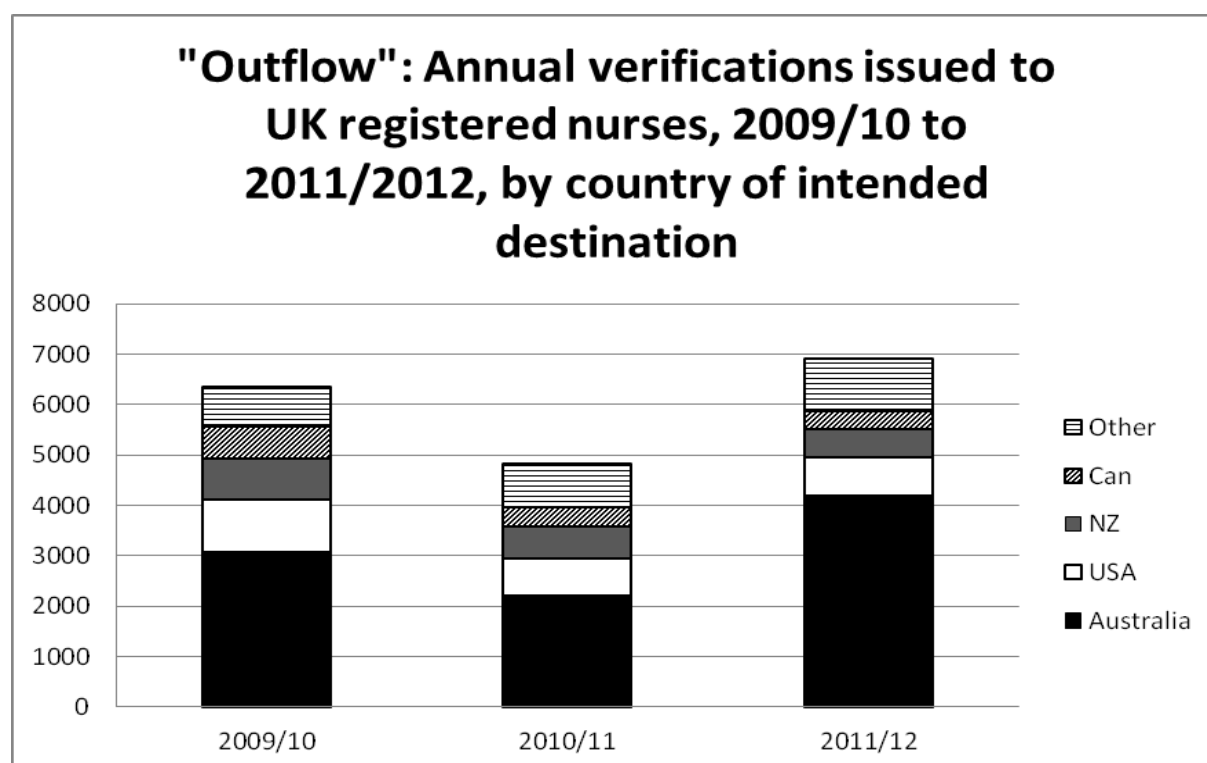
*Source: NMC/Buchan and Seccombe*

A more detailed examination of verifications issued in the last three years, in Figure 10 shows that the vast majority are issued for just four English speaking developed countries – Australia, Canada, New Zealand and the USA. Australia alone accounts for half or more of all verifications issued in 2011/12 – this amounted to 4,197 verifications. Whilst some of these will have been triggered by Australian nurses who have been working in the UK who are planning to return home, this represents a significant potential outflow<sup>17</sup>.

This data also highlights significant imbalances in flows between countries. The UK is losing nurses to Anglophone developed countries, but is mainly recruiting from EU crisis countries and from Anglophone developing countries. For example, in the same year that there were more than 4000 verifications issued for nurses considering moving from the UK to Australia, there were only 201 new registrations of Australian-trained nurses in the UK.

<sup>17</sup> Australia has recently moved from state level to national registration of nurses; it is not clear what effect, if any, this will have had on trends in NMC verification data.

**Figure 10: Outflow: annual verifications issued to UK registered nurses, 2009/10 to 2011/12, by country of intended destination**



Source: NMC/ Buchan and Seccombe

### 3.4 The international context

The pull factor on UK nurses considering moving to the traditional Anglophone developed country destinations is unlikely to reduce in the foreseeable future. In fact, a combination of growing nursing shortages, policy commitment to international recruitment whilst taking account of the WHO code may make it more likely that Australia, Canada and the USA will look to the UK as a source of nurses. Table 2 below highlights some recent studies and reports which identify future need for nurses in these countries. Various methods have been used in different studies, so the findings are not directly comparable, but it is obvious that all point to a greater gap between nurse supply and demand, or a diminishing supply. All these studies also identify the same bundle of causal factors in the nursing workforce as has been reported in the UK: ageing of the profession, burnout, and, in some countries including the UK, reduced new intakes to training.

**Table 2: Results of recent nursing workforce studies**

Country	Source	Indicator of shortage	Measure/timeline	Estimated shortage or gap
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Australia	Health Workforce Australia 2012. (Federal government agency)	Supply and demand scenarios Registered/enrolled nurses	Baseline of 258,952 in 2009. Projections to 2025	2025: 'Steady state'/do nothing scenario shows gap shortfall of <b>90,000</b> to <b>109,500</b> .
Canada	Academic researchers (Tomblin, Murphy et al., 2012)	Supply/applied needs scenarios, registered nurses	Baseline of 188,000 FTE, inn 2007; projections to 2022	2022: 259000 FTE required/ 199,000 FTE available= <b>60,000</b> shortage
USA	US Department of Labor, 2012	Projection of new jobs for registered nurses.	Baseline of 2,165,510 in 2010. Estimate for 2020	2020 Projected growth of <b>711,000</b> jobs (+26% in demand)
USA	Academic research Auerbach, 2012, 2012	Supply projections Nurse practitioners only	Baseline of 12,800 in 2008 Projections to 2015	2015: Forecast <b>94%</b> growth in NP jobs
UK	Academic research Buchan and Seccombe, 2011	Supply scenarios, NHS qualified nurses.	Baseline of 352,104 in 2010 (headcount) Projections to 2021/22	2021/22: 'Steady state' scenario shows 309,297. Reduction of <b>42,807</b> over 2010 baseline (12.2% reduction)

Sources: Health Workforce Australia 2012<sup>18</sup>; Tomblin Murphy G, Birch S, MacKenzie A, Alder R, Lethbridge L, Little L (2012)<sup>19</sup>; US Dept of Labor 2012<sup>20</sup>; Auerbach D. 2012<sup>21</sup>; Buchan and Seccombe 2011<sup>22</sup>

The other important factor to note is that several of these studies gave explicit consideration to international recruitment as a supply source and solution to domestic shortages. The report from Health Workforce Australia (HWA) estimated that Australia would have to more than double its intake to domestic nurse education if it was to reduce its current high level of reliance on international recruitment to meet self sufficiency policy commitments. HWA concluded therefore that: "it must also be recognised that immigration remains the most flexible means of meeting short-term supply gaps and will continue to feature as a significant component of workforce supply in the medium term at least."<sup>23</sup> A similar conclusion was

<sup>18</sup> [www.hwa.gov.au/health-workforce-2025](http://www.hwa.gov.au/health-workforce-2025)

<sup>19</sup> Tomblin, Murphy G, Birch S, MacKenzie A, Alder R, Lethbridge L and Little L (2012) *Eliminating the shortage of registered nurses in Canada, An exercise in applied needs based planning*. Health Policy 105 (2012) 192-202.

<sup>20</sup> Bureau of Labor Statistics, US Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition, Projections Overview*, [www.bls.gov/ooh/about/projections-overview.htm](http://www.bls.gov/ooh/about/projections-overview.htm)

<sup>21</sup> Auerbach D (2012) *Will the NP workforce Grow in the Future? New Forecasts and Implications for Healthcare Delivery*. Medical Care 50 (7) 606-610

<sup>22</sup> [www.rcn.org.uk/\\_data/assets/pdf\\_file/0006/405483/LMR2011\\_FINAL.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0006/405483/LMR2011_FINAL.pdf)

<sup>23</sup> Health Workforce Australia (2012) *Health Workforce 2025*. HWA: Adelaide

reached by a recent report on the health sector workforce in the USA which highlighted that: “Nursing will grow the fastest among health care occupations, by 26 per cent, but that won’t be enough to meet the demand. Barring some change, the shortfall will exceed 800,000 jobs, meaning the United States will have to continue to seek nurses outside its borders.”<sup>24</sup>

In the last decade, the UK – most notably England – made use of international recruitment to solve domestic shortages. In doing so, it raised controversy about the impact of active recruitment of nurses from the developing world, and also was criticised for poor co-ordination of international recruitment and domestic health workforce policies. There has recently been more lobbying to make it easier for non-EU nurses to enter the UK. In its 2011 submission to the Migration Advisory Committee, the Centre for Workforce Intelligence notes that: “Lengthy training timescales increase the attractiveness, and suitability, of migration to provide a short-term solution to labour shortages.”<sup>25</sup>

In 2007, the Health Committee of the UK Parliament noted highlighted that: “There was a clear lack of alignment between the two approaches to increasing staff numbers.”[para230] and recommended that “the Department must play a more effective role in overseeing active international recruitment by the NHS. In view of the boom and bust in international recruitment...the Department of Health needs to work more effectively with other departments, notably the Home Office, to ensure that international recruitment is fair and consistent and that those who come to the UK in response to active international recruitment receive fair treatment and equal opportunities [para 283]”<sup>26</sup>. In its follow up report in May 2012 the Committee stated: “We welcome the government view that planning of UK health and care workforce should not be dependent on significant future flows of trained staff from overseas, both to ensure security of supply and to avoid poaching skilled staff from developing countries...” [para 80].<sup>27</sup> In contrast, as noted above, some competitor countries, such as the USA and Australia, have restated their continued dependence on active international recruitment.

The broader view of nursing labour markets in the developed world suggests that many will be forced to address staff shortages in the next few years. The Organisation for Economic Co-operation and Development (OECD) in its most review of the health sector across its 34 member countries notes that “there are concerns in many countries about shortages of nurses, and these concerns may well intensify in the future as the demand for nurses

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[www.hwa.gov.au/health-workforce-2025](http://www.hwa.gov.au/health-workforce-2025)

<sup>24</sup> Carnevale A, Smith N, Gulish A, Beach B (2012) *Healthcare*. Center on Education and the Workforce, Georgetown University  
[www9.georgetown.edu/grad/gppi/hpi/cew/pdfs/Healthcare.FullReport.072512.pdf](http://www9.georgetown.edu/grad/gppi/hpi/cew/pdfs/Healthcare.FullReport.072512.pdf)

<sup>25</sup> Centre for Workforce Intelligence (2012) *Migration Advisory Committee (MAC) Shortage Occupation List Update: Healthcare Profession Submission*.  
[www.cfw.i.org.uk/publications/mac-shortage-occupation-list-update-healthcare-profession-submission-2011](http://www.cfw.i.org.uk/publications/mac-shortage-occupation-list-update-healthcare-profession-submission-2011)

<sup>26</sup> Health Committee, House of Commons (2007) *Workforce Planning: Fourth Report of Session 2006–07*. The Stationery Office, London  
[www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf](http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf)

<sup>27</sup> Health Committee, House of Commons (2012) *First Report: Education, training and workforce planning*, London: The Stationery Office Limited  
[www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/6i.pdf](http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/6i.pdf)

continues to increase and the ageing of the baby boom generation precipitates a wave of retirements among nurses” (p72)<sup>28</sup>.

### 3.5 Summary

For the time being, national policy-led international recruitment may be off the agenda in the UK, but there is clear evidence that inflow of nurses to the UK is increasing, and anecdotal evidence that some NHS trusts are now looking abroad for staff. In the past the NHS has been criticised for an aggressive and poorly co-ordinated approach to international recruitment. Much of the renewed inflow of nurses to the UK is unregulated and unmanaged, and this raises system and reputational risks. In contrast to the UK, some other developed countries are expressing a continued focus on international recruitment.

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<sup>28</sup> OECD (2012) *Health at a Glance, 2011*. OECD Paris.  
[www.oecd.org/health/healthpoliciesanddata/49105858.pdf](http://www.oecd.org/health/healthpoliciesanddata/49105858.pdf)



## 4. Trends in the use of bank and agency nursing staff

### 4.1 Introduction

In this section we examine recent trends in the use of bank and agency nurses in the NHS. In section 2, where we profiled the overall UK nursing workforce, we stressed that the paucity of data on temporary nursing was a significant gap in developing an accurate overview, and was a constraint on effective workforce planning. To the extent that the level of use of temporary staff is used as an indicator of shortages, or that there is policy consideration of greater use of flexible temporary staff, there is also a need to develop a better understanding of why temporary staff are being deployed. The specific focus on this issue in this year's LMR is because it is increasingly evident that the so called 'flexible' element of the nursing workforce is having increased policy focus. This in part is a reflection of the desire to achieve productivity improvements through effective use of temporary staff, but also, and more recently reflects a debate around increased flexible use of staff, on zero hours contracts, short contracts, etc, to achieve organisational cost savings<sup>29</sup>.

### 4.2 NHS temporary nurse staffing

NHS staffing, particularly acute hospital staffing, is complex. As well as having to cope with staff turnover, sickness and absence, professional development, there is the added challenge of matching a fixed supply (funded staff establishment) against the variable demand of fluctuating patient numbers and acuity. The employment of temporary (bank and agency) nursing staff to meet short-term fluctuations in workforce demand has been subject to considerable scrutiny over the past decade not least because it has been regarded as an area of potential cost savings through improved efficiency. Since publication of the Audit Commission's *Brief Encounters* report in 2001, attention has continued to focus on the costs, quality and management of temporary nursing staff<sup>30</sup>. In 2005 the Department of Health acknowledged the escalating expenditure on agency nursing staff within trusts and listed the need for 'managing temporary staffing costs' as one of its ten high impact workforce changes. In 2006 the National Audit Office, like the Audit Commission before it, identified poor procedures in many NHS trusts in terms of how workload assessment was used to project staffing requirements and to identify temporary staffing requirements<sup>31</sup>. This review found that, expenditure on temporary staff ranged from less than one per cent up to 29 per cent of total expenditure on nursing staff between different NHS trusts in England. Most recently NHS Professionals has produced a series of 'white papers' covering the management and costs of temporary staffing<sup>32</sup>.

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<sup>29</sup> Cusick J (2012) *Health warning over army of NHS 'temps'*, The Independent, 3 September 2012 [www.independent.co.uk/news/uk/home-news/health-warning-over-army-of-nhs-temps-8101469.html?origin=internalSearch](http://www.independent.co.uk/news/uk/home-news/health-warning-over-army-of-nhs-temps-8101469.html?origin=internalSearch)

<sup>30</sup> Audit Commission (2001) *Brief encounters: Getting the best from temporary nursing staff*. Audit Commission, London  
[www.audit-commission.gov.uk/nationalstudies/health/other/Pages/briefencounters.aspx](http://www.audit-commission.gov.uk/nationalstudies/health/other/Pages/briefencounters.aspx)

<sup>31</sup> National Audit Office (2006) *Improving the use of temporary nursing staff in NHS acute and foundation trusts*. NAO, London  
[www.nao.org.uk/publications/0506/improving\\_the\\_use\\_of\\_temporary.aspx](http://www.nao.org.uk/publications/0506/improving_the_use_of_temporary.aspx)

<sup>32</sup> The most recent of these is *Exposing the true costs of managing a temporary workforce*, NHS Professionals, January 2011. The white papers series is available at [www.nhsp.co.uk/research-papers](http://www.nhsp.co.uk/research-papers)

The main policy responses to these various reports was the development of agency framework agreements for hiring temporary staff and the establishment of NHS Professionals which aimed to reduce the dependence of the NHS on private sector nursing agencies and to improve the quality of care provided.

The arguments over whether temporary nursing staff represent a successful 'flexible firm' model of employment<sup>33</sup> or a failure to manage resources appropriately will not be examined in detail here. In this labour market review our focus is on trying to determine how large the temporary nursing workforce is and what are the recent trends in usage. However, despite being the focus of attention, it is surprisingly difficult to establish with any clarity how much temporary staffing use there is across the NHS, what it is doing and what it costs. For Wales<sup>34</sup> and Northern Ireland<sup>35</sup> no data are regularly or routinely made available on these questions, other than reports on cost trends included in Laing and Buisson's April 2012 report on NHS Finances<sup>36</sup>. These indicated that temporary staffing costs (this includes all staff groups and types of temporary staff) in Wales were 2.3 per cent, and in Northern Ireland 2.8 per cent, of permanent staff costs – in both cases substantially lower than the equivalent figure in England (7.4 per cent). In NHS England, national collation of data on bank nurses was proposed for suspension in 2011<sup>37</sup>.

The exception to this data gap is NHS Scotland where quite detailed data have been available for a number of years on the numbers of hours and costs of bank and agency nursing staff used. These are available for both registered and non-registered staff and by health board although not by health care setting.

### 4.3 Bank and agency use in NHS Scotland

The latest available data for Scotland show that in 2011/12 around 5.3 per cent of workforce capacity was provided by temporary nursing staff (5.2 per cent by bank and 0.1 per cent by agency nursing staff). This translates into a whole time equivalent of 3,159 bank and 81 agency staff between April 2011 and March 2012. Comparing these figures with those for 2006/07 shows both a downward trend in the overall use of temporary nursing staff and a shift away from agency (1.1 per cent of capacity and 728 WTE) to bank (5.6 per cent of capacity and 3,519 WTE). Expenditure on registered agency nursing and midwifery staff has fallen from over £9.4 million in 2008/09 when more than 409,000 hours were bought to £3.4 million in 2011/12 for 110,746 hours. In the last year the use of agency nurses has fallen by 10.9 per cent and expenditure is down by 9.5 per cent compared with 2010/11.

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<sup>33</sup> See for example Volberda H (1999) *Building the Flexible Firm: How to Remain Competitive* Oxford University Press, Oxford

<sup>34</sup> From 2008 onwards, all records with a WTE of zero have been excluded from the headcount of staff and consequently all 'bank' staff are excluded.

[www.statswales.wales.gov.uk/TableViewer/document.aspx?ReportId=27751](http://www.statswales.wales.gov.uk/TableViewer/document.aspx?ReportId=27751)

<sup>35</sup> No data are available on bank and agency nursing staff in Northern Ireland. The latest NI Health and Social care Workforce Census for 31 March 2011 excludes "around 12,000 bank/sessional staff and staff with a WTE of less than or equal to 0.03"

[www.dhsspsni.gov.uk/workforce\\_census\\_march\\_2011.pdf](http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf)

<sup>36</sup> Laing and Buisson (2012) *NHS Financial Information 2012*

[www.laingbuisson.co.uk/MediaCentre/PressReleases/NHScutsbackontemporarystaff.aspx](http://www.laingbuisson.co.uk/MediaCentre/PressReleases/NHScutsbackontemporarystaff.aspx)

<sup>37</sup> NHS Information Centre (2011) *NHS Nursing and Midwifery Bank Staff Return: Consultation*. NHS IC, Leeds.

[www.ic.nhs.uk/webfiles/Theme%20pages/Workforce/NHS\\_Nursing\\_and\\_Midwifery\\_Bank\\_Staff\\_Return2.pdf](http://www.ic.nhs.uk/webfiles/Theme%20pages/Workforce/NHS_Nursing_and_Midwifery_Bank_Staff_Return2.pdf)

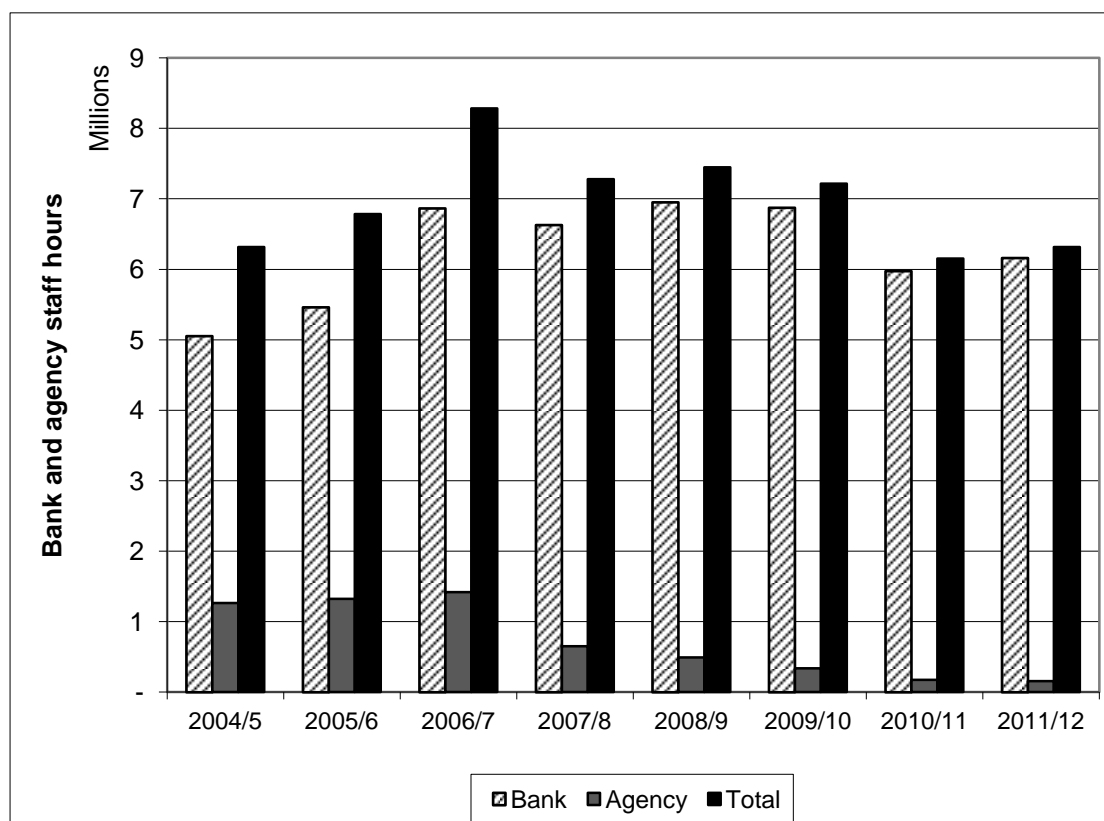
However, the overall trend is quite complex and use of temporary staff actually increased last year from 6.15m to 6.32 m hours (3,155 WTE to 3,239 WTE) with a consequent rise in expenditure from £90.5m to £94.5m.

Overall the use of agency nursing hours in Scotland continued its downward path (falling from 176,652 to 157,372 hours), although even this is a simplification since there are contrasting trends in use of registered nursing staff from agencies, which continued to decline (almost 40,000 fewer hours were used, a fall of 26 per cent), while use of non-registered nursing staff from agencies has increased very significantly (up more than 76 per cent to 46,625 hours).

At the same time the number of bank hours has increased, by 3.1 per cent, from 5.98 million to 6.16 million. Unpicking these figures further shows the reverse of the pattern observed for agency staff use. While the number of hours from bank staff in bands 5-9 rose by 8.5 per cent to 3.1 million, bands 1-4 declined by nearly 2 per cent to 3.06 million hours.

Figure 11 on page 27 summarises, and simplifies, the trend in Scotland. Overall, we can say that over recent years the trend has been for a reduction in the use of temporary nursing staff and a switch away from agency to bank staff. At the same time, the latest data show a rise in use of temporary staff particularly of bank staff in pay bands 5-9 but also in non-registered agency staff. What we don't know from these data is whether this is a one-off blip in an overall downward trend or the start of a new cycle that will see rising temporary staff use in Scotland. In part that is because we don't know what factors are driving these figures – unpredicted changes in demand, restrictions on recruitment of substantive staff or a combination of both - or whether they are short notice shift fills or longer-term dependence.

**Figure 11: Scotland: bank and agency staffing hours 2004/5 to 2011/12**



Source: ISD

#### 4.4 Bank and agency use in NHS England

While Scotland has national coverage and longer-trend data England has more detailed data but only partial coverage. NHS Professionals produce a quarterly report of national trends, which is said to provide “a unique and real-time view of trends within temporary nursing”. The data are drawn from “a statistically significant sample of the whole NHS acute and mental health trust population for England”. In fact it is based on data collected by NHS Professionals from 70 or so trusts that use their managed flexible worker services. However, it is not a complete picture since most acute trusts and all primary and community care trusts are excluded and the data are only for nursing bands 2-6. What we don’t know of course is whether these organisations are typical of the NHS in England or whether trends and patterns in their temporary staff usage are representative of the rest of the NHS in England. Nevertheless these reports do provide quite detailed information on a large sample of NHS organisations and, it is currently the best that we have.

The key trends (based on 'like for like' samples of trusts over time) highlighted in the most recent of these NHS Professionals reports (Spring 2012) are that<sup>38</sup>:

- across England, shift demand has been increasing steadily since June 2011, and accelerating since January 2012. Demand in the final quarter of 2011/12 was 18 per cent higher than the same period in 2010/11
- bank-fill has increased but not sufficient to meet the increase in demand, consequently the number of shifts filled by agencies has increased since July 2011, up 51 per cent in the final quarter of 2011/12 compared with 2010/11, representing an increase of 3.1 per cent of all demand
- demand in acute trusts was running below 2010/11 levels until July 2011. Demand grew until September, to a new plateau 20 per cent above the prior year and started again in January running through to March 2012, up 23 per cent in this final quarter
- while lower in the first quarter of 2011/12, demand in Mental Health Trusts climbed through the summer to match the previous year before dipping back through December then climbing rapidly through March 2012, up 12 per cent in the final quarter
- across acute trusts in England the number of shifts requested at short notice (i.e. with less than 24 hours' notice) has reduced by two per cent over the last 12 months to just under 20 per cent of all shift requests. This represents almost a quarter (23.4 per cent) of all agency usage.

Seasonal variations in demand for temporary staff are to be expected, with a typical peak towards the end of the annual leave period in the final quarter of the NHS year. However, NHS Professionals report that much of the additional demand seen in the last six months was unforeseen and they contrast this with the fact that many trusts were actually forecasting falling demand for cover. This ties in with the report from Laing and Buisson who reported in April that budget pressures for NHS services had led to a clear cut in temporary staffing usage by NHS organisations in 2010/2011<sup>39</sup>. The report includes various temporary staffing modes (including agency, locum, bank, secondments and short-term contracts) and all staff groups. It estimated that costs were £3.71bn in 2010/2011, shrinking by 7.4 per cent from £4.01bn in 2009/2010. In England the most acute cut backs were by PCTs which reduced their overall use of temporary staff from 9.8 per cent of staff costs to 7.9 per cent.

As in Scotland, this raises the question of what lies behind the unexpected increase in demand for temporary staff and how long will it be sustained. Without more complete data on temporary nursing staff usage, workforce planning assumptions will continue to be based on an underestimation of the workforce supply required to meet current demands.

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<sup>38</sup> NHS Professionals, *National Trends Spring 2012* [www.nhsp.co.uk/national-trends](http://www.nhsp.co.uk/national-trends)

<sup>39</sup> Laing and Buisson *NHS Financial Information 2012*  
[www.laingbuisson.co.uk/MediaCentre/PressReleases/NHScutsbackontemporarystaff.aspx](http://www.laingbuisson.co.uk/MediaCentre/PressReleases/NHScutsbackontemporarystaff.aspx)

Unfortunately the currency in which temporary staff use is reported differs – Scotland reports hours worked while England uses shifts booked – so that no common picture can be presented.

The Centre for Workforce Intelligence acknowledge this gap in their latest *Nursing Supply and Demand* June 2012 report where they state: “There is a lack of national data on the use of agency and temporary staff in nursing” and, in order to support and inform the next round of education commissioning in the autumn of 2012, indicate that they will work with various agencies including NHS Employers, the NMC and the NHS Information Centre, to provide better intelligence on the level of agency and other temporary nursing staff.

## 4.5 Summary

In this part of the LMR we have examined the fragmented data available on the use of bank and agency nurses in the NHS. Despite the growing debate around flexible use of nurse staffing, there is a poor information base on which to inform policy and planning. There is virtually no evidence on the quality and continuity of care issues related to use of temporary nursing staff, and the data that is available on level of use paints at best a fragmented picture of what is occurring<sup>40</sup>. There is also little evidence or transparency of the reasons for the use of temporary staff, beyond that of the classic short-term fill of vacant shifts. The issue of nurse workforce flexibility may be taking greater prominence, but it is not well informed by data or evidence.

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<sup>40</sup> Bae S, Mark B and Fried B (2010) *Use of temporary nurses and nurse and patient safety outcomes in acute care hospital units*. Health Care Management Review. 2010 Oct-Dec;35(4):333-44

## 5. The supply of newly-qualified nurses

### 5.1 Introduction

This chapter describes flows into and out of nursing education. We assess data on the overall trends in numbers of students starting nursing education, the numbers of education places available and the numbers of students who drop out of nursing education.

### 5.2 Starting nursing education

UK-wide statistics on the number of applications (choices) made by those seeking to enter higher education in 2012 show another substantial rise in applications (each individual can make up to five choices) for nursing degree courses (up 24.6 per cent to 197,980) compared with 156,719 in 2011<sup>41</sup>. However, a 70.4 per cent drop in the number of applications for diploma courses (down from 49,234 to 13,878), means that overall numbers of applications (choices) for all types of pre-registration nursing programmes are 211,858, up by 5,905 or 2.9 per cent. The number of applications for entry to nursing degree courses easily exceeds those of all other higher education courses (for example, pre-clinical medicine had 81,277 applications and was similarly down by 2.3 per cent on the previous year).<sup>42</sup> To put this in context, overall applications (all courses) are down by 7.3 per cent.

Overall the number of UK domiciled applicants stands at an all-time high of 58,123 (Figure 12 on page 31). Having had double digit growth rates throughout the last decade, in 2011 the growth in applicant numbers slowed dramatically to just 1.3 per cent (761) compared with 25.3 per cent in 2009 and 36.6 per cent in 2010 when numbers may have been inflated by the planned phasing out of the nursing diploma in England by 2013 and uncertainty over how changes to higher education funding arrangements would affect health care students.<sup>43</sup> Figure 12 shows the numbers of UK domiciled applicants from 2000 to 2011.

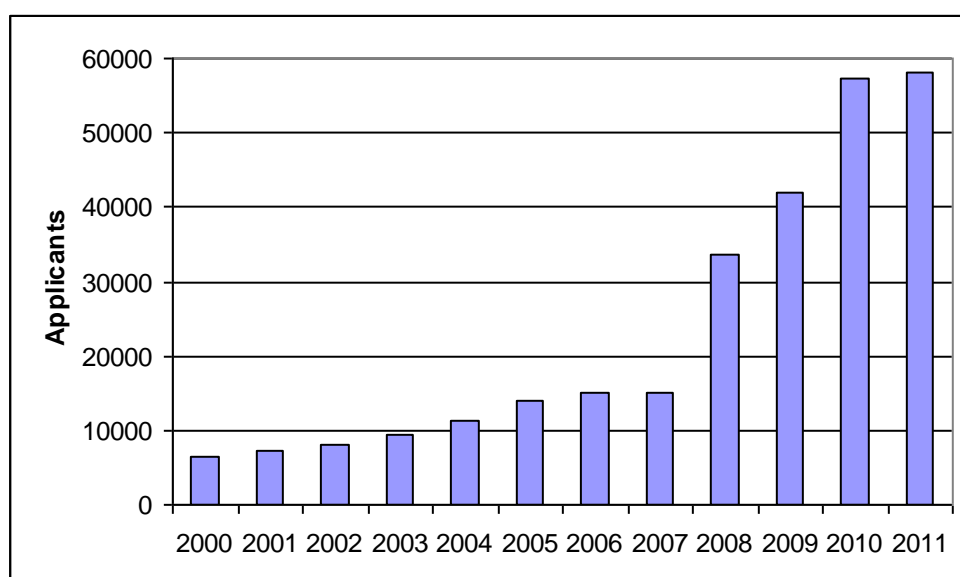
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<sup>41</sup> UCAS media release, 9 July 2012 *Application figures 30 June*.  
[www.ucas.ac.uk/about\\_us/media\\_enquiries/media\\_releases/2012/20120709](http://www.ucas.ac.uk/about_us/media_enquiries/media_releases/2012/20120709)

<sup>42</sup> UCAS media release, 31 May 2012, *2012 applicant figures – May*.  
[www.ucas.com/about\\_us/media\\_enquiries/media\\_releases/2012/20120531](http://www.ucas.com/about_us/media_enquiries/media_releases/2012/20120531)

<sup>43</sup> Some of the increase in 2010 is because the figure for that year includes applications for Scottish nursing and midwifery courses which were not previously reported through UCAS

**Figure 12: Number of UK domiciled applicants for entry to nursing education at higher education institutions, 2000 to 2011.**

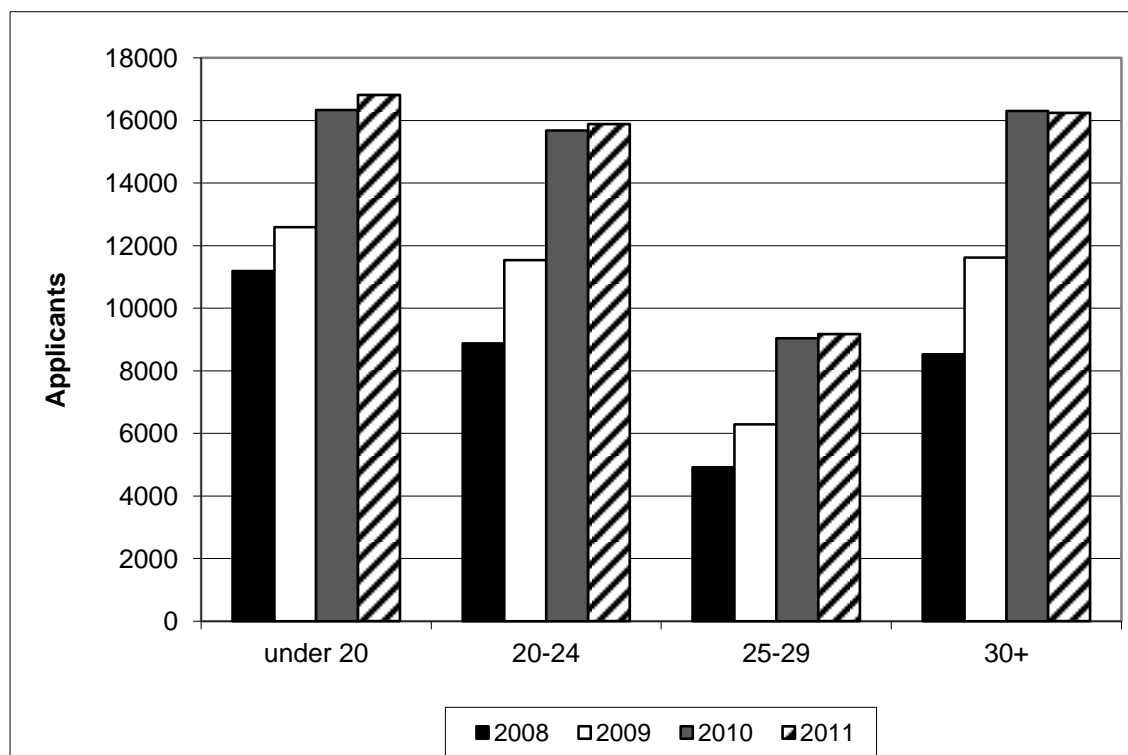


*Source: UCAS*

Previous labour market reviews have noted a distinct change in the age profile of applicants since 2008 with the proportion of applicants aged over 30 rising to equal that of the under 20s. Figure 13 illustrates this shift in age profile but shows that, in 2011, the increase in applicants has mainly been in the younger age cohorts with those aged under 25 accounting for 90 per cent of the small overall increase in applicant numbers.



**Figure 13: Age profile of UK domiciled applicants for entry to nursing degree and diploma courses, 2008 to 2011**



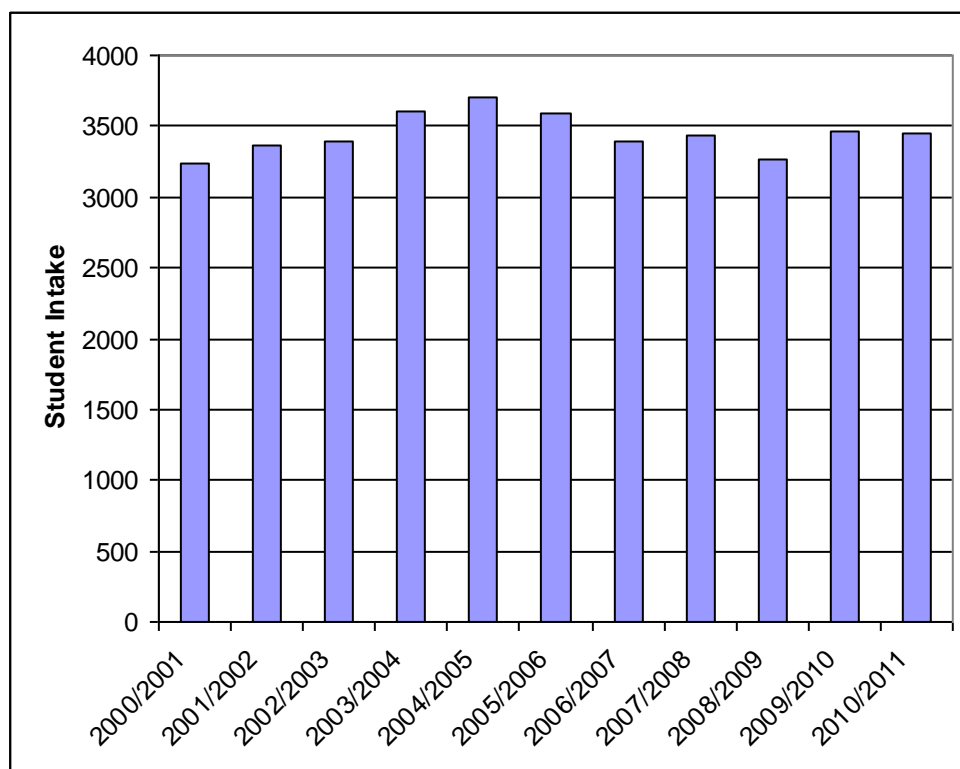
Source: UCAS

The following paragraphs briefly set out the recent trends for each of the four countries.

**England:** UCAS figures for 2011 show that the number of student applicants in England has remained more or less static, at 48,328 it is just 250 (0.5 per cent) more than in 2010. However, the number of places available has not kept pace with the demand. In 2009 UCAS figures show that 60 per cent (22,755) of applicants for diploma and degree course places were successful. The 2010 data show a fall of nearly 5 per cent, in the total number of acceptances (to 21,679) with only 45 per cent of applicants being successful. This trend has continued in 2011, with 19,483 (40 per cent) of applicants being accepted. In 2010 over 70 per cent of the successful applicants were for degree course places compared with 35 per cent in 2010.

**Scotland:** prior to 2010 most applications were not processed via UCAS. The UCAS data for 2011 shows 5,369, a drop of 2.1 per cent (117) on 2010. As in England, a falling proportion is accepted: 2,960 (55 per cent successful compared with 59 per cent in 2010) of applicants from Scotland were accepted onto a pre-registration course, down 8.9 per cent compared with 3,250 in 2010. Over 92 per cent of these successful applicants were for degree course places. Trend data are available from ISD statistics. These show that the intakes to pre-registration courses in Scotland are some way short of their 2004/05 peak (3,698) but still above the low of 2008/09 (Figure 14 on page 33). As a consequence of the mid-decade peak, the number of pre-registration nursing students in Scotland was at an all time high in 2010/11 (10,384) but this will subsequently fall as a result of the relative reduction in size of intakes in more recent years.

**Figure 14: Scotland: numbers of students starting three-year nursing and midwifery programmes, 2000/01 to 2010/11**

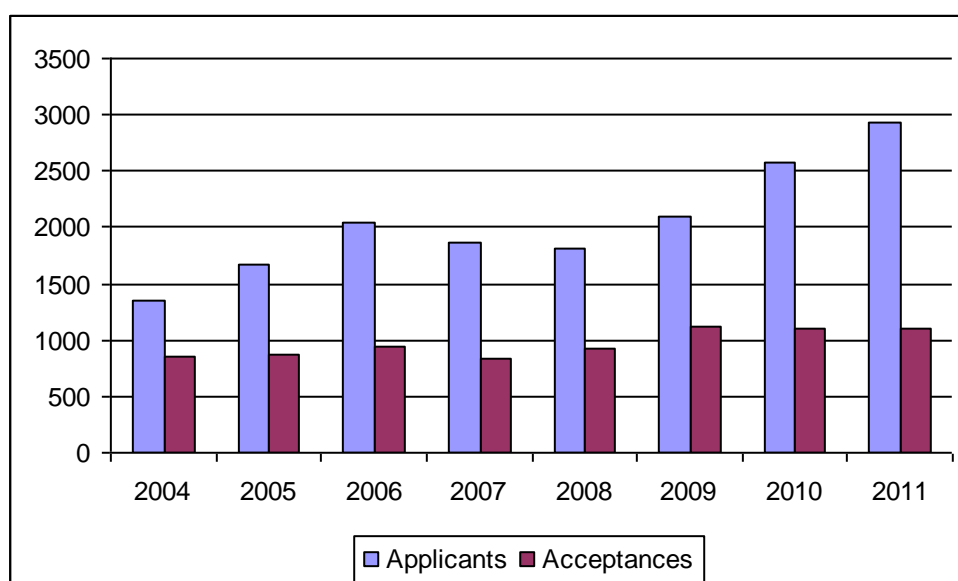


*Source: compiled from ISD statistics*

**Wales:** figures from UCAS show a contrasting picture in Wales where the number of applicants for entry to degree level courses has continued to rise steeply, increasing by 13.7 per cent from 2,585 in 2010 to 2,940 in 2011. As elsewhere however the numbers accepted haven't kept pace, rising by one per cent from 1,096 in 2010 to 1,107 in 2011 (Figure 15 on page 34) with the proportion of applicants accepted dropping from 42 per cent to 38 per cent.

**Northern Ireland:** figures from UCAS show that the number of applicants rose by 22 per cent, from 1,215 to 1,486. However, acceptances fell marginally from 506 to 498 (97 per cent were for degree courses).

**Figure 15: Wales: applicants and acceptances for pre-registration nurse education, 2004 to 2011**



Source: UCAS

### Places available

The numbers of places being commissioned for pre-registration nursing is the key determinant to future intakes to education and subsequent labour market supply. In 2011/12 there were approximately 22,640 places available across the four countries of the UK compared with 24,800 the previous year. Available figures suggest this number will reduce by about 5.6 per cent – 1,260 fewer places – in 2012/13 to a total of around 21,380<sup>44</sup>.

**England:** recently published figures show that nine out of the 10 SHAs in England plan further reductions in commissioned places this year (the exception being NHS West Midlands where numbers are expected to remain unchanged, following very large reductions in the previous year). Overall, these provisional figures reveal that the number of commissioned course places is expected to drop by 839 to 17,405 in England, a fall of 4.6 per cent which comes on top of the 9.4 per cent decline in 2011/12<sup>45</sup>. Over the past five years then the number of commissioned places in England will have fallen by more than 3,560, a drop of almost 17 per cent<sup>46</sup>. It should also be noted that actual commissioning numbers have historically been lower than the planned figures<sup>47</sup>. Supply projections modelled by the Centre for Workforce Intelligence and published earlier this year assumes

<sup>44</sup> Nursing Standard *Decrease in student places poses 'significant risk' to care standards*, May 9 2012, vol.26, no.36, p5

<sup>45</sup> Nursing Standard *Savage cuts to student numbers leave lecturers facing job losses*, 9 February 2011, vol.25, no.23, p5

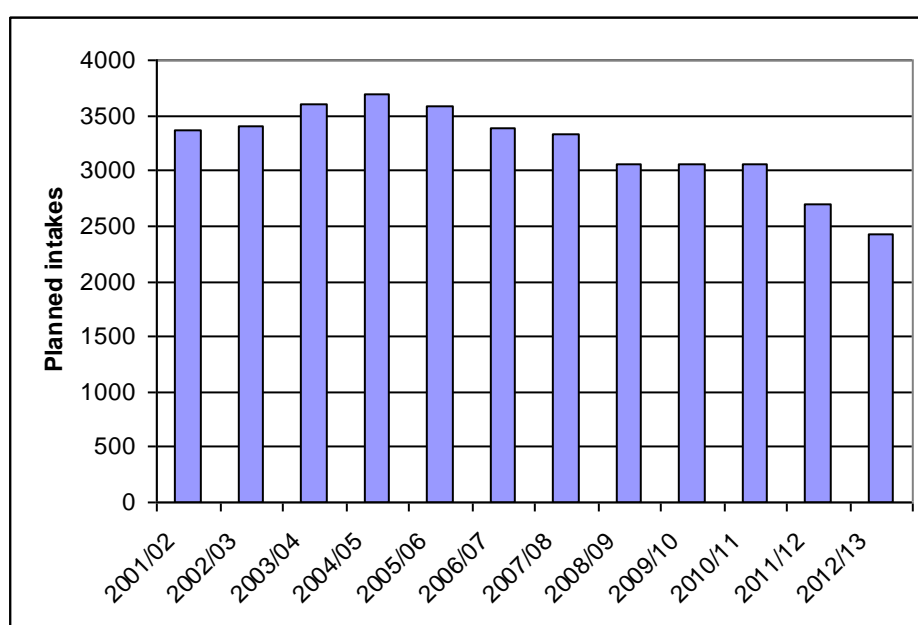
<sup>46</sup> Nursing Standard, *Experts fear reduction in student places will spark workforce crisis*, 9 May 2012, vol.26, no.36, p12

<sup>47</sup> Centre for Workforce Intelligence (2012) *Workforce risks and opportunities: adult nurses. Education commissioning risks summary from 2012*

that training commissions for adult nursing in England would be 12,017 per annum from 2011/12 onwards. That assumption is already too high as training commissions for the adult branch in 2012/13 have dropped below this level by nearly 5 per cent at 11,465.<sup>48</sup>

**Scotland:** in January 2012 the Scottish Government announced that overall student intake (pre-registration nursing and midwifery) for 2012-13 will be 2,430 - compared to 2,700 last year. That is, a drop of 10 per cent following a 12 per cent drop last year and three years when the numbers had been kept constant at 3,060 (see Figure 16)<sup>49</sup>. The reduction is based on NHS health boards' workforce projections and is said to reflect: "changing patterns of care and service delivery as well as improvements in student attrition"; (RCN Scotland has challenged this process<sup>50</sup>). Overall this represents a total reduction of more than 19 per cent in two years.

**Figure 16: Planned intake to pre-registration nursing and midwifery in Scotland, 2000/01 to 2012/13**



Source: NHS Scotland

**Wales:** in 2010 there were 1,150 places for pre-registration nursing (and 123 for midwifery). This reduced in 2011 to 1,035 (and 102 midwifery places), an overall drop of 10.7 per cent in the number of places available. A further 11.2 per cent decline is planned for 2012/13, with the number of pre-registration nursing degree places dropping to 919 (in contrast the number of midwifery places will rise slightly, to 107).

<sup>48</sup> Centre for Workforce Intelligence (2012) *ibid*

<sup>49</sup> [www.scotland.gov.uk/News/Releases/2012/01/studentnurses26012012](http://www.scotland.gov.uk/News/Releases/2012/01/studentnurses26012012)

<sup>50</sup> RCN Scotland (2011) *Written evidence submitted to the Scottish Government in October 2011 on the Nursing and Midwifery Workforce Planning Process 2011: Student Nurse and Midwife Intake 2012/13*. RCN Edinburgh.

**Northern Ireland:** the Department of Health, Social Services and Public Safety commissioned review of the nursing and midwifery workforce (2009) concluded that proposed commissioning levels for pre-registration nursing education of 748 in 2010 and 814 in 2011<sup>51</sup>. Actual commissions in were 660 in 2010/11 and 2011/12 but are due to fall to 625 in 2012/13.

### 5.3 Leaving nursing education

The number of students who leave pre-registration education without completing their course is one of the key determinants of the future supply of qualified staff. However, little data is available on this crucial flow. The only systematically reported data are those for NHS Scotland which show attrition rates for pre-registration diploma students of 27.7 per cent, 28.5 per cent and 26.3 per cent for each of the three most recent cohorts.<sup>52</sup> A 2006 report by the Scottish Executive compared attrition rates in Scotland unfavourably with those in Wales (28 per cent and 17 per cent respectively), arguing that reducing attrition to 15 per cent would (along with reducing demand for newly qualified nurses to 2,000 a year) contribute to annual savings of £26 million.<sup>53</sup> Subsequently £5 million were provided to support improvement in the student recruitment process and the learning experience. These funds were used to develop and improve the marketing of nursing careers, recruitment and selection, mentoring and practice learning as well as developing a consistent approach to the collation of data on student attrition. A more robust measurement of attrition has been introduced based not on completion at the nominal (after three years) end of the programme but completion over five years which is said to reduce variation between organisations in attrition rates by allowing for those students who take leave of absence.<sup>54</sup>

The latest figures suggest an improvement, by two percentage points, in student attrition in Scotland, from 28.5 per cent for the 2005/6 cohort to 26.3 per cent for the 2006/07 cohort. The report of the Nursing and Midwifery Student Recruitment and Retention Delivery Group suggests that recent strategies focusing on intervention and support around retention are having a positive effect and that the probability of a student entering the inactive state (ie taking a break in training or discontinuation) in the 2008 and 2009 cohorts was lower than in the 2005 to 2007 cohorts<sup>55</sup>.

Data for England also suggest that better screening of applicants and improved support for students are reducing attrition. According to Department of Health figures, the proportion of students dropping out by the end of the second year fell from 12.4 per cent for the 2008/09 intake to 8.3 per cent for the 2009/10 intake (note however that these figures are incomplete in that they exclude the final year and they do not cover London)<sup>56</sup>.

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<sup>51</sup> ASM Howarth (2009), *Final report to the DHSSPS: Review of the Nursing and Midwifery Workforce 2008-09*

<sup>52</sup> [www.isdscotland.org/Health-Topics/Workforce/Publications/2011-11-29/2011-11-29-Workforce-Report.pdf?5810183287](http://www.isdscotland.org/Health-Topics/Workforce/Publications/2011-11-29/2011-11-29-Workforce-Report.pdf?5810183287)

<sup>53</sup> Scottish Executive (2006) *Choices for a Purpose: review of Scottish Executive Budgets*, p. 77

<sup>54</sup> GHK (2012) *Final report of the evaluation of the national nursing and midwifery student Recruitment and Retention Delivery Group and Short Life Working Groups*

<sup>55</sup> NHS Education for Scotland (2011) *Untangling a complex issue: Nursing & Midwifery Student Recruitment and Retention Delivery Group Annual report 2010-11*

[www.nes.scot.nhs.uk/media/536359/delivery\\_group\\_-\\_annual\\_report\\_2010-11\\_final.pdf](http://www.nes.scot.nhs.uk/media/536359/delivery_group_-_annual_report_2010-11_final.pdf)

<sup>56</sup> Nursing Times (2011) *Huge fall in numbers dropping out of nursing courses*, 27 September

## 5.4 Summary

In this chapter we have seen that historically large numbers of students are still applying for nursing programmes but the numbers accepted and the number of commissioned places available is reducing. Consequently we can be certain that the overall numbers of newly-qualified nurses entering the labour market will fall as these reductions feeds through into the numbers graduating in the next few years. We have also seen evidence that the percentage of students who fail to complete their studies appears to be reducing significantly.

## 6. NHS workforce planning in the four UK countries

### 6.1 Introduction

To conclude, in this final chapter, we review recent development in the approach to NHS workforce planning in the four UK countries. We have highlighted in previous labour market reviews, and in this year's report, that policy makers and planners have a responsibility to assess fully the indicators and data available when making decisions on intakes to pre-registration nurse education, on retention policies, on patterns of deployment, and on international flows. All these factors are open to policy control, giving policy makers in the UK a span of control over nurse workforce planning at national level that is absent in many other countries. This degree of control brings responsibility as well as opportunity. Significant and sustained oversupply or undersupply of nurses, in the UK, is a reflection of policy decisions, not of random or external factors. As such it is critical to be confident that the planning mechanisms in place are fit for purpose and can guarantee future security of supply of sufficient nurses. We look in most detail at England, where radical restructuring is underway, but also highlight developments in the other UK countries, before concluding on the way forward.

### 6.2 England

Of the four UK countries, England is the one that is experiencing the most significant changes to the structure of the NHS, and to the approach to NHS workforce planning. As noted in the introduction, NHS England is involved in significant changes to NHS nurse workforce planning, in part driven by the reported change to an employer-led approach. Two main organisations are being formed: Health Education England (HEE) at national level, and local education and training boards (LETBs) at regional level. The view of NHS Employers is that LETBs will “identify and agree local priorities for education and training to ensure a supply of the necessary skills and people to provide health and public health services” and will consider the training needs of the whole health care workforce<sup>57</sup>.

It is becoming apparent that there are significant delays against the original timetable in establishing the new approach. At the time the Department of Health published the health workforce component of the reforms it was envisaged that HEE would be functioning by April 2012. In 2010, the department explained that: “Subject to Parliamentary approval, Health Education England will be established in shadow form in 2011 and as a special health authority to go live in April 2012”<sup>58</sup>. This initial schedule has now slipped by about one year.

Several parties have expressed concern about both the delay in implementation of the new workforce planning system and lack of clarity about its development. This was highlighted in the published summary of responses to the Department of Health consultation on the reforms, which stated that “there were numerous requests for greater detail and clarity on

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<sup>57</sup> NHS Employers (2012) *Ensuring education reform enhances patient outcome: providers' planning and driving a workforce budget of £5bn*. NHS Employers, London.

[www.nhsemployers.org/Aboutus/Publications/Pages/education\\_reform\\_outcomes.aspx](http://www.nhsemployers.org/Aboutus/Publications/Pages/education_reform_outcomes.aspx)

<sup>58</sup> Department of Health (2010) *Liberating the NHS: Developing the healthcare workforce*.

[www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_129702.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129702.pdf)

HEE's role and functions" (para3.8).<sup>59</sup> By the beginning of 2012 it was evident that there would be significant delays against the initial timetable in setting up the new system. The NHS Future Forum, in its report published in early 2012 on educating and training the NHS workforce made 27 recommendations, including stating that LETBs "should lead work with local partners, including professional representatives, to develop the quality of nurse and midwife training locally"<sup>60</sup>. This should be replicated for all clinical training programmes" (recommendation 20), and that HEE and LETBs "should work with the range of stakeholders, including the CfWI, to set out the strategic direction for the development of the workforce to more effectively meet the changing needs of patients and communities" (recommendation 27). That the forum made these recommendations at all highlighted a lack of progress in decision making around the future of NHS workforce planning.

The Department of Health has stated that it "will have strategic responsibility for new and existing bodies, including Health Education England, which will take responsibility for workforce planning, education and training for the NHS". Health Education England was established as a special health authority in July 2012, will operate in 'shadow form' from October 2012, and will be 'fully operational' by April 2013. Their website notes that: "In due course, HEE will be established as an Executive Non-Departmental Public Body, operating on a statutory basis at arm's length from the Department of Health". Up until 1 April 2013, responsibility for the education and training system, and for the associated multi professional education and training budget (MPET), remains with the Department of Health and strategic health authorities.

The Health Committee, in its report on NHS workforce planning and commissioning published in May 2012, was critical of the slow pace of implementation of the new workforce planning arrangements, the lack of clarity of the roles and responsibilities of different organisations in the new system, and the "vague and indeterminate" role of LETBs. A report in the *Nursing Times* also suggested that the Department of Health has required HEE and LETBs to cut running costs by one third, about £44million less than the education and training functions of the strategic health authorities that they will replace<sup>61</sup>.

### 6.3 Northern Ireland

In Northern Ireland, the Department of Health Department of Health, Social Services and Public Safety (DHSSPS) "has a role in ensuring that sufficient suitably qualified staff are available to meet the needs of the service overall"<sup>62</sup>. The workforce planning cycle is supported by periodic reviews, carried out at regional level across the main professions with the main aim of establishing information on the supply/demand dynamics relevant to the workforce group, in order to inform the department's decision making on the number of training places to be commissioned and to develop understanding recruitment, retention and career progression.

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<sup>59</sup> Department of Health (2011) *Liberating the NHS: Developing the healthcare workforce. Summary of consultation responses*

<sup>60</sup> NHS Future Forum (2012) *Education and Training: Next Stage. A Report from the NHS Future Forum*

<sup>61</sup> Lintern S (2012) *New education and training bodies to face financial squeeze*, Nursing Times, 4 July

[www.nursingtimes.net/new-education-and-training-bodies-to-face-financial-squeeze/5046544.article](http://www.nursingtimes.net/new-education-and-training-bodies-to-face-financial-squeeze/5046544.article)

<sup>62</sup> [www.dhsspsni.gov.uk/index/hrd/wpu/wpu-planning.htm](http://www.dhsspsni.gov.uk/index/hrd/wpu/wpu-planning.htm)



## 6.4 Scotland

Workforce planning in NHS Scotland is a statutory requirement, having been established in 2005 with the *National Workforce Planning Framework 2005 Guidance*, which provided health boards with a base for establishing workforce planning as a key element of the wider planning systems within the NHS<sup>63</sup>. A common approach to workforce planning is used across the system; the 'Six Steps Methodology to Integrated Workforce Planning'. The six steps comprise: Defining the plan; Service change; Defining the required workforce; Workforce capability; Action plan; and Implementation and monitoring. All NHS boards are expected to discuss their workforce projections with their local area partnership forums (APFs).

NHS Scotland is also currently developing a '2020 Workforce Vision' with three work streams: staff governance and engagement; leadership and capability; and capacity and modernisation. This work is planned to be completed in June 2013<sup>64</sup>.

## 6.5 Wales

In Wales a health workforce framework was published in 2012 to support *Together for Health*, the Government of Wales' five-year vision for the NHS in Wales<sup>65</sup>. It has four main objectives:

- to develop an engaged workforce – including annual appraisals, personal development plans and workforce surveys
- to ensure a sustainable and skilled workforce with staff as ambassadors, championing healthy choices
- to redesign the workforce to support a sustainable NHS – actively involving staff in planning future services
- to focus on quality and safety within challenging financial times – and to ensure improvements are integrated into everyday working.

There is an emphasis on health workforce sustainability, integration of services, and competence-based plans built around care pathways, using workforce modelling and scenario planning. Workforce efficiency targets and productivity measures have been developed, including sickness absence, level of locum/agency use, and management costs.

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<sup>63</sup> [www.scotland.gov.uk/Publications/2012/08/7784/4](http://www.scotland.gov.uk/Publications/2012/08/7784/4)

<sup>64</sup> [www.scotland.gov.uk/Topics/Health/NHS-Workforce/Policy/2020-Vision](http://www.scotland.gov.uk/Topics/Health/NHS-Workforce/Policy/2020-Vision)

<sup>65</sup> Government of Wales (2012) *Working Differently – Working Together: A workforce and organisational development framework*. Cardiff.  
[wales.gov.uk/docs/dhss/publications/120517workingen.pdf](http://wales.gov.uk/docs/dhss/publications/120517workingen.pdf)

## 6.6 The way forward: planning fit for purpose?

We noted in the introduction to this year's LMR that any assessment of the NHS nursing workforce must start from a position of acknowledging that NHS funding levels are a major determinant both of the current profile, and likely future shape of the profession. The NHS is the sole provider of funds for home based education of 'new' nurses to enter the UK nursing labour market, and is the main source of employment for qualified nurses. In addition, government policy plays a major role in facilitating, or blocking, entry to the UK of non-EU nurses. It is evident that across all four UK countries, there will be very little growth, if any, in spending on the NHS across the next few years; the NAO predicts declines in real term expenditure in three of the four UK countries.

NHS funding constraints are a factor in nurse workforce policy and planning all four UK countries. This is exerting a downward pressure on funds for workforce employment, education and development. The result is evidence of staffing decline, reductions in planned intakes to pre-registration nurse education, and reports of pressure at local level both on funds for in-service training/CPD, and on maintaining nurses in advanced roles and specialist posts<sup>66</sup>. In a mixed and often confusing picture, there are also reports of some NHS employers having to hire more nurses because of patient safety concerns<sup>67</sup>. Planners and employers have to function within affordability constraints, but they must also assess fully the options and alternatives, and take account of patient safety, demand and labour market issues beyond this year's budget.

Planners and policy makers also need to function from an informed standpoint. In recent years in the LMR we have highlighted major gaps and limitations in the available data on the nursing workforce. Most notably there is incomplete and eroding data on nurses working in non NHS sectors, inadequate data on flows of nurses between sectors and regions, inconsistent data on attrition of nursing students, and diminishing information on NHS temporary nurses in England. The effectiveness of planning, locally and nationally, is undermined by weak information, and policy is made on the basis of inadequate evidence.

In England, as described in this report, an additional and interrelated factor of major top down reform is underway, which will further develop a mixed economy of providers. Much of the policy attention has been on the shape of the new system - on creating the new planning infrastructure, on reassigning tasks, on appointing or redeploying senior staff, and this process is now well behind the initial schedule.

There has been much less clarity and detail, as noted by the Health Select Committee, on the respective roles and functions of the new agencies, on how they will interact with each other, within the NHS and in the broader context. Insufficient focus is being placed on how NHS workforce planning can be made effective in a significantly different health system, what exactly employer led means in practice in a mixed economy of providers, and how it should be embedded in broader health systems structures, to support the attainment of key

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<sup>66</sup> see eg Calkin S (2012) *Emergency nurse practitioners needed to avert A&E crisis*. Nursing Times, 3 October

[www.nursingtimes.net/5049991.article?referrer=e1](http://www.nursingtimes.net/5049991.article?referrer=e1)

<sup>67</sup> Lintern S (2012) *Trusts forced to hire more nursing staff to ensure safety*. Nursing Times, 25 September

[www.nursingtimes.net/nursing-practice/clinical-zones/management/trusts-forced-to-hire-more-nursing-staff-to-ensure-safety/5049682.article](http://www.nursingtimes.net/nursing-practice/clinical-zones/management/trusts-forced-to-hire-more-nursing-staff-to-ensure-safety/5049682.article)

system objectives such as integration between social care and NHS care, and a shift to community-based care. Workforce planning 'form' should follow on from agreed functions, not the reverse<sup>68</sup>. Planning must engage the main stakeholders in assessing the need for change and in devising strategies to achieve those changes, and will not be effective without sufficient technical capacity and adequate data on the labour market dynamics<sup>69</sup>.

Previous experience in the 1990s with locally driven NHS workforce planning highlights that there is a considerable risk of creating undersupply with a locally led approach to planning<sup>70</sup>. Where there is cost containment pressure in the NHS, local employers too often take a narrow, local view of their future requirements, without taking sufficient account of changed demand (eg when patient acuity increases with faster patient throughput) and of labour market dynamics and staff flows. These narrow views are aggregated up to regional and national level and if there are not sufficient checks and balances made to consider wider labour market dynamics, then the end result can be a significant underestimate of future requirements for nursing staff. In addition, in the past, the localised approach did not give sufficient attention to the staffing needs of non-NHS employers. The Health Committee report earlier this year again highlighted concerns about the need for more effective engagement with, and participation of, non NHS employers in workforce planning, development and education.

Experience in the 1990s gives a real-life case study in what can go wrong with locally-based planning in a national system, if it is not mitigated by a well-developed process of oversight. As noted earlier in this report the annual number of nurse entrants to the UK register fell year on year in the 1990s to a historical low in 1997/98; the direct result of a locally-based planning approach and funding decisions to reduce the number of pre-registration places on offer earlier in the decade<sup>71</sup>. The consequent drop in UK entrants to the nursing register was predictable, given decisions to reduce funding for pre-registration places, and was a major factor contributing to acknowledged nursing shortages later in the decade, and the boom and bust cycle of planning.

It is becoming clearer that NHS nurse staffing levels in England are likely to reduce significantly over the next five to 10 years if current policies and trends continue. If this is the intended result of policy decisions then these should be made explicit; if it is the result of policy inaction in the face of evidence to the contrary, then it should be highlighted. If, however, the policy debate, informed by workforce planning, concludes that there is a need to maintain NHS nurse staffing levels then policy makers must review current policies with a view to improving domestic pre-registration education levels, and/or improving retention and productivity, and/or increasing international recruitment.

Security of supply has become a recent watchword in NHS workforce planning. This, presumably, means that there should be some degree of planned, sustained and predictable inflow of nursing staff to maintain the required level workforce. Without policy change, the

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<sup>68</sup> Grumbach K (2009) *Redesign of the Health Care Delivery System: A Bauhaus Form Follows Function Approach*, Journal of the American Medical Association, 302(21), 2363-4

<sup>69</sup> Dussault G, Buchan J, Sermeus W and Padaiga Z (2010) *Assessing future health workforce needs*, WHO Observatory, Brussels

[www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/124417/e94295.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/124417/e94295.pdf)

<sup>70</sup> Buchan J, Seccombe I, Smith G (1998) *Nurses' work: an analysis of the UK nursing labour market* Aldershot: Ashgate Press

<sup>71</sup> Buchan J, Seccombe I, and Smith G (1998) *Nurses' work: an analysis of the UK nursing labour market* Aldershot: Ashgate Press

overall policy direction of the NHS in England is now towards reduced nurse staffing. Whilst comparable workforce scenario projections are not publically available to assess the future situation in the other three countries, all UK countries face the same funding pressures, the same apparent trend of reduced intakes, and the same challenge of retaining an ageing workforce. Across the UK there is a growing risk of insecurity of future nurse supply.



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